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MEDICARE CATASTROPHIC LOSS PREVENTION ACT OF 1987

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Mr. BENTSEN, from the Committee on Finance, submitted the following

REPORT

[To accompany S. 1127]

The Committee on Finance, to which was referred the bill (S. 1127) to provide for medicare catastrophic illness coverage, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute to the text, and recommends that the bill as amended do pass.

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I. BACKGROUND AND NEED FOR LEGISLATION

The Medicare Catastrophic Loss Prevention Act of 1987 protects Medicare beneficiaries from catastrophic expenses associated with covered Medicare services. This legislation responds to the concern that Medicare, which currently has no upper limit on cost-sharing charges, does not offer protection against catastrophic hospital and physicians expenses.

The Medicare program was designed to meet the acute health care needs of the elderly. Fairly extensive coverage is provided for short-term hospital stays under Medicare Part A. However, coverage for long-term hospital stays is less adequate. These stays are subject to significant coinsurance charges, though less than 1% of beneficiaries face such charges in a given year. Further, a beneficiary may potentially exhaust all hospital benefits.

Beneficiaries enrolled in the Part B program pay a monthly premium ($17.90 in 1987). They are also liable for certain charges in connection with their use of physicians and other services covered under the program. All beneficiaries are liable for the $75 deductible and 20 percent coinsurance charges. In addition, where a physician or other provider does not accept "assignment" (i.e., does not agree to accept Medicare's determination of "reasonable charge" as payment in full for covered services), the beneficiary is liable for the difference between Medicare's reasonable charge and the physician's actual charge. This is commonly referred to as "balance billing."

The Congressional Budget Office estimates that liabilities for Medicare copayments will average $456 in 1987; an additional $105 represents average liability for "balance billing" charges by physicians. Thus total liabilities in connection with covered services are an estimated $561 per enrollee. However, the liability for Medicare cost-sharing charges is not distributed evenly throughout the population. Copayment liabilities are highest for those with inpatient stays and for those with renal disease. Those with hospital stays comprise 22 percent of the enrollee population but are liable for 70 percent of out-of-pocket costs. For those with one inpatient stay, the average liability is $1,335. For the 0.5 percent of enrollees who use some hospital coinsurance days, the average out-of-pocket liability is $7,657. Additionally, enrollees with renal disease comprise only 0.4 percent of enrollees but are liable for 3.7 percent of out-of-pocket costs.

An estimated 72 percent of Medicare beneficiaries have purchased so-called Medigap policies, i.e., private insurance coverage to supplement Medicare's benefit package. The principal protection offered by the majority of these policies is coverage of Medicare's cost-sharing charges. Some policies cover a limited number of additional services not covered by Medicare, such as prescription drugs. Insurance premiums for this protection will average between $500 and $600 in 1987; however both coverage and costs vary considerably among policies. An estimated 8 percent of enrollees are also covered by State Medicaid programs. These programs vary substantially in terms of eligibility, scope of coverage, and payment of benefits, though they generally provide protection against high out-of-pocket payments for dual enrollees.

The elderly with lower incomes and higher health care needs are the least likely to have either private supplementary coverage or Medicaid protection. In 1984, 20 percent of the elderly had no additional coverage. Nearly 30 percent of persons with family incomes below $9,000 were without additional coverage compared to only 10 percent of enrollees with family incomes over $25,000. Although health care needs rise with age, so did the likelihood of being without supplemental private insurance coverage or Medicaid. Seventeen percent of enrollees between age 65 and 69 lacked additional coverage while 27 percent age 80 and over had no such protection.

A number of services used by the elderly are not covered under Medicare. These include prescription drugs, eyeglasses, hearing aids, dentures, and most long-term care services. Beneficiaries are liable, therefore, for health care costs in addition to cost-sharing charges associated with covered Medicare services. In 1984, per capita out-of-pocket payments by the elderly totalled $1,059 or 25 percent of their total health care bill. These amounts do not include the additional amounts spent by the elderly for payment of the Part B premiums or private insurance premiums. It has been estimated that mean out-of-pocket payments (including insurance premiums) as a percentage of mean income was 15 percent in 1984. However, these figures are averages. They may be higher or lower for individual beneficiaries depending on individual circumstances such as age, incidence of acute illness, the presence of chronic conditions, and other insurance coverage. The impact of these expenditures may be particularly severe for those lower income aged without other health coverage.

The Center for Health Policy Studies, Georgetown University School of Medicine, has made projections of the elderly's out-of-pocket expenses for acute care as a percentage of per capita income for 1986. Excluding long-term care costs, the elderly with incomes under $5,000 are estimated to spend 18 percent of their incomes on medical care while those with incomes over $20,000 are estimated to spend only 4 percent of their incomes on medical care. Almost one-quarter (23.8 percent) of elderly persons are estimated to spend over 15 percent of their income on medical bills (not including those for long term care) and 7.7 percent are estimated to spend over 25 percent of their incomes on such bills.

The Committee bill addresses itself to filling the gaps in Medicare's acute care benefits. It is expected that the administrative costs of providing the additional coverage will be substantially less than those currently associated with coverage under Medigap policies. While all who benefit from the new program will pay an additional amount, those with higher incomes will pay more than those with lower incomes.

The bill substantially improves Medicare benefits by adding catastrophic coverage. In developing a funding mechanism for such improvements, the committee followed four basic principles. First, the funding mechanism should cover the cost of the benefit improvements, both in the short-term and the long-term. Second, the committee believed that the cost of the benefit improvements should be borne by those receiving the benefits. Third, the committee believed that all those who benefit from the added coverage should pay something for that coverage, but that the burden be based in part on the ability to pay. Fourth, the committee believed that the receipt of catastrophic coverage, and the payment of the associated premiums, should be on a voluntary basis like current Part B Medicare coverage.

In light of these principles, the committee determined that the catastrophic benefits should be financed by the combination of (1) an increase in the basic Part B monthly premium, and (2) a new income-related supplemental premium collected through the income tax system. Both the basic premium and the income-related premium are indexed directly to increases in the cost of the new catastrophic benefits. This will result in the program being self-financing in the short-term and the long-term.

Under the bill, the Part B premium generally is increased by $4 per month beginning in April of 1988. This additional premium is indexed to the per enrollee cost of the new catastrophic benefit.

The supplemental premium is to be collected only from individuals enrolled in Medicare Part B and with Federal income tax liability greater than or equal to $150. Unlike the existing Part B premium, which is the same for all Part B enrollees regardless of income, the supplemental premium increases according to the enrollee's tax liability. The supplemental premium is $1.02 per month of Part B enrollment per $150 of Federal income tax liability for taxable years beginning before 1989. The supplemental premium is indexed to the per enrollee cost of the new catastrophic benefit.

The supplemental premium is capped so that the sum of the Part B and the maximum supplemental premiums always is less than the value of Part B coverage (including the new catastrophic benefits). The cap is $800 per enrollee in 1988, increasing to $1,000 in 1992. After 1992, the cap is 65 percent of the excess of the value of Medicare Part B coverage over the Part B monthly premium (including the additional Part B premium to fund the new catastrophic benefit).

The Committee recognizes that the bill does not provide protection against the costs associated with noncovered Medicare services such as prescription drugs, long-term care, and balance billing charges. However, the Committee views the bill as an important step in protecting the elderly against high medical expenses.

II. EXPLANATION OF BILL

Section 1. Short Title; Reference in the Act

Explanation of provision.—The provision specifies that the Act may be cited as the "Medicare Catastrophic Loss Prevention Act of 1987". The provision would further specify that the references in the Act, unless otherwise stated, are to the Social Security Act.

Section 2. Scope of Benefits Under Part A

Current law.—Under current law, the scope of inpatient hospital and skilled nursing benefits available to a beneficiary is linked to the individual's benefit period or spell of illness. A benefit period is defined as beginning when a beneficiary enters a hospital or skilled nursing facility and ending when he or she has not been in a hospital or skilled nursing facility for 60 days.

During each spell of illness, the Part A program pays for 60 days of inpatient hospital care subject to a deductible. The beneficiary is entitled to an additional 30 days of care, subject to a daily coinsurance charge. In addition, the beneficiary has a lifetime reserve of 60 days of added coverage (subject to a daily coinsurance charge) after the 90 days have been exhausted. After the beneficiary has received 90 days of care in a benefit period and exhausted the 60 lifetime reserve days, Medicare reimbursement ceases and the beneficiary is liable for all additional hospital charges during that spell of illness.

Under current law, special limits apply to inpatient services in a psychiatric hospital. Payment may not be made for more than 190 days of inpatient hospital services furnished in a psychiatric hospital in an individual's lifetime (the so-called lifetime limit). The Part A program also includes an inpatient psychiatric carryover restriction for individuals who are in a participating psychiatric hospital on the first day of an individual's entitlement. All days during the immediately preceding 150 days during which the individual was an inpatient of a psychiatric hospital are deducted from the initial benefit period. Such days do not count toward the lifetime limit.

During each spell of illness, the Part A program pays for up to 100 days of post-hospital extended care services in a qualified skilled nursing facility (SNF).

SNF services are covered under Medicare only if the individual has been a hospital inpatient for at least three consecutive days and is admitted to the SNF within 30 days after the hospital discharge. Furthermore, the extended care services must have been necessitated by a condition which necessitated the patient's hospital stay. Congress provided in the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248, known as TEFRA) that the Secretary provide for coverage of extended care services that do not follow a hospitalization if the inclusion of such coverage would not result in any increase in the total payments made for extended care services and if it would not alter the acute care nature of the benefit. The Secretary has not used the TEFRA authority to eliminate the prior hospitalization requirement.

Explanation of provision.—The bill would make a number of changes in the scope of Medicare Part A benefits for those voluntarily enrolling in the Part B program. For those not electing Part B coverage, current law Part A provisions relating to coverage of hospital and skilled nursing facility benefits would continue to apply.

For beneficiaries voluntarily enrolling in the Part B program, the bill would eliminate the spell of illness concept and provide for unlimited hospital days and up to 150 days of SNF services during a calendar year. Further, the bill would repeal the inpatient psychiatric carryover restriction for those beneficiaries voluntarily enrolling in Part B. In addition, the bill would eliminate the prior hospitalization requirement to receive extended care services for beneficiaries enrolling in Part B.

Effective date.—Applies to items and services furnished after December 31, 1987, except that in the case of beneficiaries receiving SNF services on December 31, 1987, the changes would not apply until the individual's spell of illness had ended.

Section 3. Deductibles and Coinsurance Under Part A

Current Law.—Under current law, beneficiaries are liable for specified deductibles and coinsurance charges in connection with their use of inpatient hospital services and skilled nursing facility services. During each spell of illness, beneficiaries are required to pay an inpatient hospital deductible ($520 in 1987). A daily copayment equal to ¼th of the hospital deductible ($130 in 1987) is required for the 61st through 90th day. Lifetime reserve days are subject to a daily copayment charge equal to ½ of the inpatient hospital deductible ($260 in 1987). Beneficiaries using skilled nursing facility services are required to pay a daily coinsurance charge equal to ⅛ of the inpatient hospital deductible ($65 in 1987) for the 21st through 100th days.

Under current law a beneficiary is also required to pay a separate deductible equal to the first three pints of whole blood (or equivalent quantities of red blood cells) received by the beneficiary during each spell of illness.

Explanation of provision.—The bill would make a number of changes in the requisite deductible and coinsurance charges for inpatient hospital and skilled nursing facility services for persons voluntarily enrolling in the Part B program. These changes would be made in conjunction with the changes in the scope of Part A benefits authorized under Section 2 of the bill. For persons not voluntarily enrolling in Part B, the current law Part A deductible and coinsurance charges would continue to apply.

For beneficiaries voluntarily enrolling in the Part B program, one inpatient hospital deductible would be required for the first period of continuous hospitalization that begins in a calendar year. Beneficiaries who pay a deductible for an admission in December of a calendar year would not be required to pay an additional hospital deductible for a period of hospitalization beginning in January of the following year. The law would be further modified to provide that the blood deductible would apply to the first three pints of whole blood furnished each year rather than during each spell of illness.

For beneficiaries voluntarily enrolling the Part B program, the current SNF coinsurance requirements would be modified. These beneficiaries would be required to pay coinsurance for the first 10 days of covered SNF services, not to exceed 10 days in a year. The coinsurance amount for each day would be equal to 15 percent of the national average per diem reasonable cost recognized under Medicare for extended care services. The Secretary would be required in September of each year (beginning with 1987) to promulgate the coinsurance amount that shall apply to SNF services in the following year. This is estimated to be $18 in 1988.

Effective date.—Applies to items and services furnished after December 31, 1987, with the following exceptions. Beneficiaries whose spell of illness begins before January 1, 1988 and whose period of hospitalization included in that spell of illness begins on or after January 1, 1988 and before February 1, 1988 would not have an inpatient hospital deductible imposed for that period of hospitalization. Further, in the case of beneficiaries receiving SNF services on December 31, 1987, the changes would not apply until the individual's spell of illness had ended.

Section 4. Limitation on Cost-Sharing

Current law.—Under current law, beneficiaries are liable for specific deductible and coinsurance charges in connection with their use of inpatient hospital, skilled nursing facility, and hospice services and blood under Part A.

Beneficiaries voluntarily enrolling in Part B are required to pay a monthly premium. The Part B program generally pays 80 percent of the reasonable charge for physicians and other medical services (including immunosuppressive drugs furnished within one year of an organ transplant) after the beneficiary has met a $75 deductible. The beneficiary is liable for the remaining 20 percent known as coinsurance. In addition, where a physician does not accept assignment (i.e., does not agree to accept Medicare's determination of reasonable charge as payment in full for covered services), the beneficiary is liable for the difference between Medicare's reasonable charge amount and the physician's actual charge. This is sometimes referred to as the "balance billed" amount. A beneficiary is also required to pay a separate Part B blood deductible equal to the first three pints of whole blood received in connection with Part B services during a calendar year. (This is in addition to any blood deductible required to be paid under Part A in connection with inpatient services.) The law contains no upper limit on the amount of cost-sharing charges beneficiaries are required to pay in connection with covered Medicare services.

Explanation of provision.—The bill would establish an upper limit on beneficiary cost-sharing charges in connection with covered Medicare services. Only beneficiaries enrolled in Part B would be eligible for this limit. The catastrophic limit would be set at $1,700 in 1988. For succeeding years, the limit would equal the limit for the preceding year, increased by the cost-of-living adjustment (COLA) to Social Security benefits. The Secretary would be required to promulgate the Medicare catastrophic limit for a year by November 15 of the preceding year.

The bill would specify certain beneficiary expenses which would count toward the catastrophic limit. These are: the inpatient hospital deductible, skilled nursing facility coinsurance charges, hospice coinsurance charges, Parts A and B blood deductibles, and the Part B deductible and coinsurance amounts. Additionally, beneficiary expenses for immunosuppressive drugs furnished after the first year following an organ transplant would count toward the limit; countable expenses could not exceed reasonable charges. Beneficiary payments for balance billed amounts would not count toward the catastrophic limit.

The bill would also count toward the catastrophic limit certain expenses made by beneficiaries for specified routine examinations though these services are not covered services under the Medicare program. Specifically countable toward the catastrophic cap would be reasonable charges for: a) one routine mammography examination every three years for female Medicare beneficiaries aged 55 or older; and b) colorectal examinations each year for Medicare beneficiaries aged 65 or older. The Committee expects that the colorectal examination would include:

(1) One digital rectal examination per year when not provided as part of a routine physical examination, i.e., when provided as part of a general physical exam these examinations should not be billed separately.

(2) One office guaiac test and up to 3 mail guaiac tests per year.

(3) One sigmoidoscopy for those with a physical indication or a family or individual medical history of colorectal cancer.

The Committee expects the Secretary to establish and apply appropriate utilization guidelines for each of these tests. The Committee notes that the American Cancer Society recommends a sigmoidoscopy only every three to five years following two annual exams with negative results.

The bill would provide that after a beneficiary had incurred out-of-pocket expenses in a calendar year equal to the catastrophic limit, Medicare would pay 100% of the requisite cost-sharing amounts for: inpatient hospital services, extended care services, hospice services, Parts A and B blood supplies, and covered Part B services.

The bill would require the Secretary to provide for an appropriate adjustment in Medicare payment amounts to prepaid health care organizations paid on the basis of reasonable cost and to renal dialysis facilities. The adjustment is to reflect the increase in payments to such organization as if payments were made on an individual by individual basis. Such organizations and facilities would be required to assure the Secretary that they would not charge individuals eligible for Medicare catastrophic coverage for covered services after the individual had reached the catastrophic limit. The purpose of this requirement is to prevent the organization from receiving duplicate payments. The organization may accomplish this in an actuarial manner rather than by tracking each individual's expenditures and adjusting his payments to the organization after he has reached the cap. (See section 10 for provisions relating to risk-based prepaid health care organizations).

The bill would specify that institutional providers with agreements with the Medicare program would be prohibited from charging Medicare beneficiaries for services for which catastrophic benefit payments are made to the provider. No comparable limitation would apply with respect to balance billing charges by physicians.

Effective date.—Applies to items and services furnished after December 31, 1987. In 1988 only, only those expenses incurred on or after July 1, 1988 could count toward the catastrophic limit.

Section 5. Increase in Part B Premium

Current law.—Under current law, the Secretary is required to calculate and announce each September the amount of the monthly premium that will be charged in the following calendar year for Part B enrollees. Premium incomes were originally intended to finance half the costs of the Part B program. However beginning in 1973, the annual percentage increase could not exceed the annual cost-of-living adjustment (COLA) in social security cash payments. As a result, the percentage paid through beneficiary premiums declined to less than 25 percent of the total. The remaining portion is paid by Federal general revenues.

A temporary provision of law requires for calendar years 1984–1988 that the premium amount be calculated so as to produce premium income equal to 25 percent of program costs for the aged. If the premium increase is greater than the social security COLA, the premium increase is to be reduced so as to avoid a reduction in the individual's social security check. Beginning January 1, 1989, the premium calculation reverts to the method under which the annual increase may not exceed the COLA.

Explanation of provision.—The bill would provide for the financing of catastrophic benefits through a combination of an increase in the Part B premium and an income-related supplemental premium. The increase in the Part B premium would be paid by all beneficiaries enrolled in the Part B program.

The bill would provide for the calculation of a catastrophic coverage premium amount which would be added to the basic Part B premium amount. The catastrophic coverage premium amount would be $4 in 1988. The monthly catastrophic coverage premium amount for succeeding calendar years would be the amount for the preceding year increased (or decreased) by the percentage increase (or decrease) in the per capita actuarial costs of catastrophic benefits (and associated administrative costs). The indexing rate for 1989 and 1990 would be increased slightly both to account for the timing difference between implementation of the indexed premium and the actual collection of the premium and to insure the actuarial soundness of the premium. The Committee bill would provide that the catastrophic coverage premium amount would be appropriately reduced for persons covered under Part B but not Part A.

The catastrophic coverage premium amount would be added to the basic Part B premium amount. Current law requirements relating to the calculation of the basic Part B premium amounts would remain unchanged. Thus, beginning in 1989, the annual percentage increase in the basic premium amount could not exceed the social security COLA. The bill would provide that beginning January 1, 1989, if the catastrophic premium increase for an individual is greater than the dollar amount of the social security increase for that individual, the premium increase would be reduced so as to avoid a reduction in social security benefits.

The bill would also provide for periodic transfers from the Supplementary Medical Insurance Trust Fund to the Federal Hospital Insurance Trust Fund to account for expansions in Part A benefits for Part B enrollees.

Effective date.—Applies to premiums for months beginning after December 31, 1987.

Section 6. Supplemental Premium for Catastrophic Illness Coverage

Current law.—Under current law, all individuals who are age 65 or older may elect to enroll in the Medicare supplemental medical insurance program (Part B) by paying the monthly premium. Individuals who have not attained age 65 but who are eligible for the Medicare hospital insurance program (Part A) by virtue of disability or end-stage renal disease may also elect to enroll in Part B by paying the monthly premium. The monthly premium in 1987 is $17.90.

Explanation of Provisions

In general.—In general, under the bill, an individual who receives Medicare Part B coverage for any portion of a taxable year and who has Federal income tax liability greater than or equal to $150 for such year, is required to pay a supplemental premium based on the individual's Federal income tax liability for that year. For purposes of the Internal Revenue Code, this premium generally is to be treated in the same manner as an addition to income tax and thus is to be paid and collected in the same manner as an income tax. However, this premium is treated as a medical expense for purposes of section 213 of the Code (which allows a deduction for medical expenses in excess of 7.5 percent of adjusted gross income (AGI)) in the taxable year following the taxable year to which the premium relates.

Amount of the supplemental premium.—Under the bill, the amount of the applicable supplemental premium imposed on any individual is determined as follows. The applicable supplemental premium equals the monthly supplemental premium multiplied by the number of months in a taxable year in which the individual received Medicare Part B coverage. The monthly supplemental premium, in turn, equals the "premium rate" for the taxable year multiplied by a specified amount that depends on the individual's tax liability.

The premium rate used to determine the monthly supplemental premium is $1.02 for any taxable year beginning before 1989. The specified amount that is multiplied by the premium rate to determine the monthly supplemental premium is calculated by dividing the individual's Federal income tax liability for the taxable year by $150 and then rounding the result to the next lowest number. Thus, for example, if an individual has less than $150 of Federal income tax liability, the specified amount for such individual is zero.

For purposes of this determination, the term "Federal income tax liability" means the tax imposed by Chapter 1 of the Code (without regard to this provision) reduced by the amount of the earned income credit and the amount of nonrefundable credits allowed under Part IV of Subchapter A of Chapter 1.

The $1.02 premium rate is to be adjusted for taxable years beginning after 1988 in accordance with the percentage increase or decrease in the per enrollee actuarial comprehensive catastrophic benefit amount (within the meaning of sec. 1839(g)(2)(C)(ii) of the Social Security Act as added by the bill) for the calendar year in which the taxable year begins as compared to the preceding calendar year. An appropriate adjustment applies to taxable years beginning in 1989. In addition, the Secretary is directed to adjust the otherwise applicable premium rate for any taxable year beginning in a calendar year after 1992 to prevent inappropriate increases or decreases in the applicable supplemental premium attributable to certain changes in the average Federal income tax liability of individuals required to pay the supplemental premium.

For years beginning after 1992, the Secretary is further directed to increase the premium rate and the monthly catastrophic coverage premium (in proportional amounts) to the extent necessary so that the estimated total catastrophic coverage revenues collectable for liabilities arising in such year equals the total catastrophic coverage benefits (within the meaning of section 1839(g)(2)(C)(i)) and related administrative costs incurred in such year.

The applicable supplemental premium for any individual in a taxable year is subject to a limit. For taxable years beginning after 1987 and before 1993, the limit is the amount specified below multiplied by a fraction the numerator of which is the number of months in the taxable year in which the individual received Part B coverage, and the denominator of which is 12. The amount to be multiplied by this fraction is:

If the taxable year begins in:	**The amount is:**
1988	$800
1989	850
1990	900
1991	950
1992	1,000

In the case of a taxable year beginning after 1992, the limit is 65 percent of, in effect, the excess of the value of the basic Part B coverage and the catastrophic coverage over the premiums charged for such coverage (other than the applicable supplemental premium). For this purpose, the premiums are to be determined without regard to section 1839(f)(2) or 1839(g)(3) of the Social Security Act (prohibiting an increase in such premiums with respect to an individual to the extent that such increase would reduce the net social security benefit payable to such individual).

Treatment of joint returns.—In general, if a married couple files a joint return, the applicable supplemental premium is to be determined as if the husband and wife were one individual. Thus, the joint Federal income tax liability is used to determine the monthly supplemental premium applicable to the couple. The monthly supplemental premium, as so determined, is then multiplied by the number of months in the taxable year in which the "individual" received Part B coverage. For this purpose, the individual is the spouse with the higher number of months (or if the number of months is the same for both spouses, either spouse).

The limitation on the applicable supplemental premium for a married couple filing a joint return (if both spouses received Part B coverage during the year) is the sum of the limits that would apply to each spouse if determined separately under the general rule.

Collection of the supplemental premium.—In general, for purposes of the Code, the applicable supplemental premium is to be treated in the same manner as an addition to income tax and thus is to be paid and collected in the same manner as an income tax. However, for purposes of determining (1) the amount of credits allowable under Chapter 1 of the Code, and (2) the amount of the minimum tax imposed by section 55 of the Code, the applicable supplemental premium is not to be considered an addition to income tax.

Notwithstanding the general treatment of the applicable supplemental premium as an addition to income tax, it is treated as a medical expense for purposes of section 213 (which allows a deduction for medical expenses in excess of 7.5 percent of AGI) in the taxable year following the taxable year to which the premium relates.

Transfers to the Part B Trust Fund.—The Secretary of the Treasury shall, from time to time, transfer from the general fund of the Treasury to the Federal Supplementary Medical Insurance Trust Fund amounts equal to the aggregate applicable supplemental premiums paid plus the net savings to the Federal Government under the Medicaid program attributable to this bill. This transfer is to be appropriately adjusted to the extent that prior transfers were in excess of or less than the correct amount.

Information reporting.—The bill requires that the Secretary of Health and Human Services make an information return stating (1) the name and address of each individual covered by Medicare Part B at any time during the calendar year, and (2) the number of months such individual is so covered.

Effective date.—The applicable supplemental premium provision of the bill is effective for taxable years ending after December 31, 1987.

Section 7. Medicare Coverage of Home Health Services on a Daily Basis

Current law.—Under current law home health services are covered under Medicare if the services are required because the individual is homebound and requires skilled nursing care on an intermittent basis or physical or speech therapy. Current program guidelines specify that to meet the requirement for intermittent skilled nursing care, an individual must have medically predictable recurring need for skilled nursing services. The guidelines define "intermittent" as permitting daily skilled nursing visits for up to eight hours a day for up to two or three weeks if medically reasonable and necessary. Daily is defined as five, six, or seven days per week.

Explanation of provision.—The bill would clarify that daily is defined as seven days a week with one or more visits per day. Such care may be provided for a period of up to 21 days with a physician's certification of the need for such care and services on a daily basis.

The bill would extend the number of days for which beneficiaries enrolled in Part B could receive daily home health benefits. For these beneficiaries, 45 days of daily care would be allowed if the beneficiary were discharged from either a hospital or skilled nursing facility within 30 days prior to beginning home health care.

Effective date.—Applies to services furnished after December 31, 1987.

Section 8. Clarification of Requirement That Individual Be Confined to Home To Be Eligible for Home Health Services

Current law.—Under current law, an individual must be confined to his or her home in order to receive home health services. This is known as the homebound requirement.

Explanation of provision.—The bill would clarify the definition of homebound. It would specify that an individual shall be considered to be confined to his home if: (a) the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the aid of a supporting device (such as crutches, a cane, a wheelchair, or a walker); or (b) the individual has a condition such that leaving his or her home is medically contraindicated. The bill would provide that an individual does not actually have to be bedridden to be considered homebound. However, the individual's condition should be such that there exists a normal inability to leave home, that leaving home would require a considerable and taxing effort, and that absences from the home are infrequent or of relatively short duration.

Effective date.—Applies to services furnished after December 31, 1987.

Section 9. Annual Notice to Medicare Beneficiaries

Current law.—Under existing law, there is no requirement for an annual notice to Medicare beneficiaries about the scope of benefits available to them under the Medicare program. Information on Medicare coverage is generally available through Social Security Administration district offices.

Explanation of provision.—The bill would require the Secretary to notify annually each Medicare beneficiary of the benefits available and categories of health care not covered under Medicare, Medicare payment limitations (including deductibles and coinsurance), and the way payment limitations for beneficiaries covered by Part B differ from those for beneficiaries not covered by Part B. The bill requires that such notice also be provided when an individual applies for benefits under Part A or enrolls in Part B, and annually thereafter. It requires that the notice be prepared in consultation with groups representing the elderly and with health insurers.

Effective date.—The requirement to provide notices to new beneficiaries is effective January 1, 1988. The notice to all beneficiaries applies to annual notices beginning for 1988.

Section 10. Adjustment of AAPCC's and Contracts for Risk-Based Organizations

Current law.—Section 1876 of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982, provides for Medicare payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) on either a risk or a cost contracting basis. In general, risk contracting plans are financially responsible for the cost of all benefits their enrollees would otherwise be eligible for under Medicare. Reimbursement of HMOs and CMPs is determined based on estimates of the average adjusted per capita cost (AAPCC) and the adjusted community rate (ACR).

Explanation of provision.—The bill requires the Secretary to modify for eligible risk-based organizations (under Section 1876 of the Social Security Act) the adjusted average per capita cost (AAPCC) to reflect the catastrophic coverage provided in this bill. It requires the Secretary to modify each contract for portions of contract years occurring after December 31, 1987 to reflect the changes made in the AAPCC. In addition, each risk-based organization is required to make appropriate adjustments in terms of its agreements with Medicare beneficiaries to take into account the catastrophic coverage provided under the bill.

Effective date.—Enactment.

Section 11. Study of Treatment of Prescription Drugs

Current law.—Under current law, Medicare generally pays for prescription drugs only when they cannot be self-administered, are furnished as an incident to a physician's service, and are included in the physician's bill. Drugs furnished as part of inpatient services are included within the payment to the provider. Immunosuppressive drugs furnished to a beneficiary who receives an organ transplant are covered for one year after the date of the transplant as a Part B service, subject to the Part B deductible and coinsurance requirements. Limited drug payments are also included as part of the hospice benefit.

Explanation of provision.—The bill requires the Secretary to request the National Academy of Sciences, acting through the Institute of Medicine, to study and report on additional drugs, available by prescription only, that might be covered under Medicare, or counted toward the catastrophic limit. The study is to include analyses and recommendations with respect to appropriate payment limits. The Institute of Medicine is required to provide an interim report on the study to Congress within 6 months of the bill's enactment and a final report, including specific findings and recommendations, within 12 months of enactment.

Effective date.—Enactment.

Section 12. Hospice Care

Current law.—Under current law, a beneficiary who is terminally ill may elect to receive hospice services for two 90 day periods and one subsequent 30 day period for a total of 210 days during his lifetime. Beneficiaries making this election must choose to receive services through a hospice and give up most other Medicare benefits. At the expiration of 210 days of covered hospice care, the patient's revocation of other Medicare benefits ends. A patient may continue to use hospice services. In this case the patient will be charged, to the extent he or she can afford to pay, for hospice services not otherwise covered by Medicare.

Explanation of provision.—The bill would eliminate the maximum 210 day limit on hospice coverage for all Medicare beneficiaries. A Medicare beneficiary would be entitled to an indefinite subsequent extension period if the medical director or attending physician recertifies at the beginning of such period that the individual is terminally ill.

Effective date.—Enactment.

Section 13. Voluntary Certification of Medicare Supplemental Health Insurance Policies

(a) Establishment of new model standards

Current law.—Under section 1882 of the Social Security Act (commonly referred to as the Baucus amendment), insurers who market private insurance policies to fill the gaps in Medicare may have the policies certified by the Secretary of Health and Human Services if the policies meet minimum standards. These standards are contained in a model state program approved by the National Association of Insurance Commissioners (NAIC) on June 1, 1979, and are incorporated by reference in section 1882 of the Social Security Act. Policies that are certified by the Secretary may be marketed as Medigap policies. However, if a State has adopted laws and/or regulations at least as stringent as those of the NAIC, policies regulated by the State are deemed to meet Federal requirements. Currently 46 States, the District of Columbia, and Puerto Rico meet these requirements.

The model standards require Medigap policies to: (1) cover all of the Medicare Part A inpatient coinsurance for the 61st through 90th day in the hospital, and the 60 lifetime reserve days, plus 90 percent of covered hospital inpatient expenses for a lifetime maximum of up to 365 days after the insured has exhausted Medicare benefits; (2) cover 20 percent of the amount of Medicare eligible expenses under Part B, subject to a calendar maximum out-of-pocket deductible of $200 and a maximum benefit of at least $5000 in a given calendar year; (3) not contain waivers to exclude, limit or reduce coverage or benefits for more than 6 months for pre-existing diseases or physical conditions that were diagnosed or treated within 6 months before the effective date of the coverage; (4) automatically change as Medicare's deductibles and coinsurance requirements are changed; (5) have a "free look" period, during which an individual may return an unwanted policy for cancellation and receive a full refund on any premium paid; (6) provide cancellation and termination clauses to be prominently displayed; and (7) at the time of sale, provide an outline of coverage for a Medicare supplement policy.

The Baucus amendment also provides for loss ratio targets for Medigap policies that set a goal for the percentage of insurance premiums to be returned to policyholders in the form of benefits. Medigap policies must be expected to pay benefits at least equal to 60 percent of the earned premiums for individual policies and 75 percent for group policies.

Under the Baucus amendment, there are federal sanctions, consisting of fines and/or imprisonment, for: (1) furnishing false information to obtain the Secretary's certification, (2) posing as a federal agent to sell Medigap policies, (3) knowingly selling policies that duplicate coverage the individual already has, and (4) selling supplemental policies by mail in states that have not approved, or are deemed not to have approved, their sale.

It has been argued that Medigap or private supplemental insurance policies are already meeting the catastrophic medical needs of the elderly. About seventy percent of the elderly buy Medigap insurance. However, according to a recent study by the General Accounting Office (GAO/HRD-87-8), many of these policies are inefficient Medicare supplements. On average, commercial policies return only 60 cents on the dollar in benefits. The remaining 40 cents represents administrative and marketing costs and profits. GAO computed that a majority of the commercial Medigap policies (64 percent) fell below the loss ratio targets established under the Baucus amendment. However, the 34 percent of policies that were above the targets were for those policies most frequently purchased. For individual commercial policies, GAO found that Medicare beneficiaries were receiving 60 cents in benefits for every $1 in premiums. For the Blue Cross/Blue Shield individual policies, the return was 81 cents in benefits for every $1 in premiums. Some policies had low loss ratios because of waiting periods for certain conditions when the policy would not cover services.

Approximately 2 percent of Medicare spending is for administrative costs, which means that the remaining 98 percent is spent for benefits. The Medicare program also does not deny benefits for preexisting conditions.

The likelihood of a Medicare beneficiary having a Medigap policy increases with family income. In 1984, 44 percent of those with incomes under $5,000 were covered, compared with 87 percent of those with incomes of $25,000 or more. Low-income elderly, therefore, are often without the supplemental policies that could help them to meet the costs of catastrophic illnesses.

Explanation of provision.—The bill provides that if the National Association of Insurance Commissioners revises the existing standards for Medigap policies within 90 days after enactment, then those standards will apply as the standard for certification, beginning one year later. If the National Association of Insurance Commissioners does not revise the standards within 90 days, the bill requires the Secretary to issue Federal model standards within 90 days, to become effective one year later.

Effective date.—Enactment.

(b) Free look period

Current law.—Under the existing NAIC standards, Medigap policies are required to provide a "free look" period of 10 days for policies sold by agents and 30 days for policies sold by mail, during which a policyholder may return the policy and get a full refund of any premium paid.

Explanation of provision.—Section 1882 is amended to require a uniform 30-day free look period for all Medigap policies, whether sold by agents or by mail.

Effective date.—Applies to policies sold once the new model standards are implemented.

(c) Loss ratios

Current law.—Section 1882 requires that Medigap policies must be expected to pay benefits at least equal to 60 percent of the earned premiums for individual policies and 75 percent for group policies. Policies issued as a result of solicitations through the mails or by mass media advertising are considered individual policies.

HHS has interpreted the requirement for expected loss ratios as not requiring state regulators to monitor the actual loss ratios of Medigap policies.

Explanation of provision.—The law would be amended to require states which have approved certification programs to adopt reporting forms developed by the National Association of Insurance Commissioners in order to collect information on actual loss ratios.

The Committee intends that, under this new requirement, the NAIC would review the feasibility and appropriateness of alternatives for informing consumers about Medigap standards including adding to the model standards an additional requirement that each Medigap policy have printed on it the loss ratio for that policy.

Effective date.—Applies to policies sold once the new model standards are implemented.

(d) Consumer information

Current law.—Section 1882 requires that the Secretary provide to individual Medicare beneficiaries information that will permit them to assess the value of the Medicare supplement policies to them and the relationship of any such policies to benefits under the Medicare program.

Explanation of provision.—The bill would amend Section 1882 to require the Secretary of Health and Human Services to (i) inform Medicare beneficiaries about current laws that prohibit certain marketing and sales abuses, (ii) establish a toll-free number for beneficiaries to report prohibited practices to the Inspector General, and (iii) inform Medicare beneficiaries of the addresses and telephone numbers of appropriate State and Federal offices where information and assistance relating to private insurance coverage and Medicare benefits may be obtained.

Effective date.—Enactment.

Section 14. Determination of Medicaid Savings; State Plan Requirements

Current law.—An estimated 2.4 million aged and disabled Medicare enrollees are also covered by State Medicaid programs. All State Medicaid plans, except for Wyoming, pay the monthly Part B premium for dual enrollees under a "buy-in" agreement. While States may "buy-in" to Part B for both their cash and noncash assistance populations, Federal matching for premium payments is available only for the cash assistance group. If a State does not buy-in for Part B coverage, it cannot receive Federal matching payments for medical services which would have been covered under Medicare if there were such an arrangement. Some States also pay some or all of the Medicare coinsurance and deductible amounts. Federal matching is available for these costs.

P.L. 99-509 created an optional categorically needy coverage group under Medicaid composed of elderly and disabled persons with incomes up to a State-established level that does not exceed 100 percent of the Federal poverty line. A State choosing this option would have to either offer the benefit package available to other categorically needy beneficiaries or alternatively cover just the Medicare cost-sharing charges. A State electing either option would also be required to cover some newly eligible pregnant women and children. The expanded coverage provision is effective July 1, 1987.

Explanation of provision.—Under the catastrophic coverage provisions of the bill, States would pay a reduced amount for those individuals for whom they currently pay the Medicare deductibles and coinsurance. The bill would require the Secretary, before the beginning of each fiscal year, to estimate the amount that each State Medicaid program would have spent from State funds under Medicaid in such year in the absence of the catastrophic coverage provisions. The Secretary would be required to notify States of this amount.

The bill would require each State Medicaid plan as a condition of approval, to spend an amount equal to its estimated savings on one or both of the following: (a) providing Medicaid coverage for Medicare-cost-sharing charges on behalf of newly eligible aged and disabled Medicare beneficiaries, pursuant to the provisions of P.L. 99-509; or (b) increasing the maintenance needs levels applicable under the plan for the community spouses of institutionalized individuals. The amounts expended under this requirement would have to be in addition to any amounts which would have been expanded for such purposes pursuant to the provisions of the State plan in effect prior to enactment of this Act. States electing, under this provision, to pay Medicare cost-sharing charges would be exempt from the OBRA requirement that a State must also cover newly eligible pregnant women and children.

Effective date.—The provision would be effective for 12 calendar quarters beginning January 1, 1988, except that delay would be permitted where State legislation is required. If the beginning date is later than January 1, 1988, the 12 calendar quarters begins on that later date.

Section 15. Studies of Long-Term Care

(a) Institute of Medicine study of long-term care

Current law.—Under current law, Medicare does not cover services required for individuals whose chronic conditions require long-term nursing home or home and community-based services.

Explanation of provision.—The bill would require the Secretary to request the National Academy of Sciences through The Institute of Medicine to study options for the private funding of a portion of long-term care, including Federal incentives to facilitate this funding, the effect of private funding on public funding of such care, options for public sector long-term care coverage, the effectiveness and cost of community-based long-term care services, and the sources of funding from individuals for each long-term care option. The bill requires the Institute of Medicine to report to the Secretary and to Congress by October 1, 1989 on the study, data obtained, and administrative action and changes in law appropriate to implement the study's findings.

Effective date.—Enactment.

(b) Department of Treasury study of tax incentives for long-term care

Current law.—There is no current requirement that the Secretary of Treasury conduct a study on the financing of long-term care. The President has asked the Department of Treasury to review tax policy as it affects the provision of catastrophic and long-term care health insurance.

Explanation of provision.—The bill would require the Secretary of the Treasury to conduct a study and make recommendations prior to April 1, 1988 with respect to tax policies to encourage the private financing of long-term care. The study would examine long-term care provided by nursing homes, home health programs, and other service delivery mechanisms. The Secretary would be required to seek the views of the insurance industry and of providers of long-term care.

Effective date.—Enactment.

Section 16. Case Management Demonstration Projects

Current law.—"Case management" is a system under which a designated person or organization has responsibility for overseeing health care services for individuals assigned to the person or organization. Where case management is used, an insurer usually will not pay (or will pay less) for those services that are provided without permission of the case manager.

Under current law, there are no requirements for Medicare beneficiaries to receive case management services and case management is not a covered service under the Medicare program. Utilization and quality control peer review organizations (PROs) are responsible for reviewing the necessity and quality of services for Medicare beneficiaries.

Explanation of provision.—The bill would require that the Department of Health and Human Services establish not less than six projects to demonstrate the feasibility of applying case management to Medicare beneficiaries with catastrophic illnesses. The substitution of lower-cost, medically appropriate services is desirable. Complicated long-stay cases should benefit from rigorous case management to hold down costs. Better coordination of services can be a substantial benefit to ensure that the most appropriate and cost effective services are identified and available to patients. Such coordination, in the form of case management, is a growing practice in the private sector and has been an optional service under the Medicaid program since April 1986. In view of the relative acceptance of case management and the benefits that it provides, the Committee believes that it would be useful to demonstrate the effectiveness of and methodology for case management for Medicare patients with selected catastrophic illnesses.

Under the demonstration project, PROs, using existing screening mechanisms, would identify cases that are at risk for becoming high cost or long stay and which might benefit from coordination of services, discharge follow-up and post-hospital support services. PROs or case managers under contract with PROs would provide the case management services. Nurse case reviewers would work with the physician and other providers to ensure the provision of medically necessary services. The nurse reviewer could disseminate information to patients and their physicians regarding the availability of various treatment alternatives and specialized care facilities.

The Committee recognizes that under current Medicare law beneficiaries are free to choose their own physician, hospital, and other providers. The Committee does not intend that the demonstrations will alter that freedom-of-choice.

The demonstration projects once established would provide case management services for one year, with total funding limited to $2 million, to be transferred directly from the Medicare Trust Funds.

At the end of the first six full months of experience, the demonstration PROs will report to the Secretary on the results of these 1 demonstrations. The Secretary will combine the results of these demonstrations with evaluations of other case management research under the Medicare program to report to the Congress on the need for introduction of case management under Medicare and the best approach to take in designing and implementing such a program.

Effective date.—The Secretary is required to have the demonstrations in place 12 months after enactment. The interim reports are due 6 months from the date on which the demonstrations are initiated.

Section 17. Repeal of Authority To Administer Proficiency Examinations

Current law.—Section 1123 of the Social Security Act allows the use of a testing program to determine the proficiency of individuals who desire to become skilled medical technicians. In the conduct of such tests, no individual who otherwise meets the proficiency requirements for the health care specialty can be denied a satisfactory proficiency rating solely because of his failure to meet formal educational or professional membership requirements. Currently, persons who are judged proficient as a result of this test may avoid going through an accredited education program designed to train such personnel.

Explanation of provision.—Section 1123 would be repealed. The repeal of this provision would not effect the exam scheduled for August 1987, nor would it effect the status of individuals who were certified by reason of previously administered exams.

Effective date.—October 1, 1987.

Section 18. Trustee Comments on Actuarial Soundness of Basic and Supplemental Catastrophic Benefit Premiums

Current law.—Under current law, the Social Security Act requires that the Trustees of the Hospital Insurance and Supplementary Medical Insurance trust funds report to the Congress not later than April 1 of each year on the operation and status of the trust funds during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next two fiscal years.

Explanation of provision.—The Committee's bill would require that the Trustees of the Medicare trust funds comment in their annual reports with respect to the actuarial soundness of the monthly catastrophic coverage premium and the supplemental premium to cover the cost of catastrophic benefits.

Effective date.—Effective for Trustees' annual reports beginning with those issued for 1988.

Section 19. Home and Community-Based Waiver Technical Change

Current law.—Under current law, the Secretary of HHS is authorized to waive certain Medicaid requirements to allow States to provide a broad range of home and community-based long-term care services. These services are for individuals who would otherwise require, and have paid for by Medicaid, the level of care provided in a hospital, skilled nursing facility, or intermediate care facility. Waivers to provide home and community-based services are frequently referred to as 2176 waivers after the section in the Omnibus Budget Reconciliation Act of 1981 which originally authorized them. Under the 2176 waiver program, the Secretary of HHS is allowed to waive two specific Medicaid requirements: (1) a requirement that Medicaid services be available throughout a State (known as statewideness) and (2) a requirement that covered services be equal in amount, duration, and scope for various groups eligible for Medicaid benefits in a State (known as comparability). By allowing the Secretary to waive these requirements, the enabling legislation intended to provide the States flexibility to offer selected 2176 home and community-based services in only a portion of the State, rather than in all geographic jurisdictions as would be required absent the waiver, and to offer selected services to certain State-defined individuals eligible for Medicaid assistance, rather than offering such services to all persons in particular groups. In addition, States have been able to extend to waiver participants the more liberal Medicaid income eligibility rules that may be applied to persons in institutions.

An amendment enacted in the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) was intended to clarify the Secretary's authority to waive the comparability of services requirement for all recipients. Instead the provision deleted the ability of the Secretary to waive the income eligibility rules for medically needy recipients.

Explanation of provision.—The bill would restore the ability of the Secretary to extend to waiver participants the income eligibility rules that apply to persons in institutions.

Effective date.—Enactment.

Section 20. Technical Amendments Relating to New Jersey Respite Care Pilot Project

Current law.—Medicaid does not currently cover respite care services except where provided under a home and community-based services waiver approved by the Secertary under section 1915(c). However, section 9414 of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509, also known as OBRA) established a respite care pilot project under the Medicaid program in New Jersey.

The Health Care Financing Administration has interpreted section 9414 to require a formal waiver. To implement the pilot project, the Committee believes that certain technical corrections to OBRA are necessary.

Explanation of provision.—Section 9414 of OBRA is modified to provide that (i) a description of the project is required rather than a formal waiver request; (ii) the State may use a post-eligibility cost sharing formula, based on available income; and (iii) eligible participants will be defined.

Effective date.—Enactment

III. HEARINGS

The Committee on Finance held hearings on catastrophic health insurance proposals on January 28, 1987, March 19, 1987, and March 26, 1987.

IV. COMMITTEE VOTE

The Committee on Finance considered S. 1127 on May 28 and May 29, 1987. On May 29, 1987, the Committee ordered the bill reported with an amendment by a rollcall vote of 20-0.

V. COSTS OF CARRYING OUT THE BILL

U.S. Congress,
Congressional Budget Office,
Washington, DC, July 2, 1987.

Hon. Lloyd Bentsen,
Chairman, Committee on Finance,
U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for S. 1127, the Medicare Catastrophic Loss Prevention Act of 1987, as ordered reported on May 29, 1987, by the Committee on Finance.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

ROBERT F. HALE
(For Edward M. Gramlich, Acting Director).

Congressional Budget Office Cost Estimate

1. Bill number: S. 1127.
2. Bill title: The Medicare Catastrophic Loss Prevention Act of 1987.
3. Bill status: As ordered reported by the Committee on Finance on May 29, 1987.
4. Bill purpose: To amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the Medicare program, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
DIRECT SPENDING/OFFSETTING RECEIPTS					
Hospital Inpatient Benefits:					
Eliminating the limit on covered hospital days:					
Budget authority	205	315	360	395	440
Outlays	180	300	345	380	420
Eliminating enrollees' copayments for hospital coinsurance and reserve days:					
Budget authority	330	510	580	640	710
Outlays	295	485	560	615	680
Limiting payment of the hospital deductible to the first stay each year:					
Budget authority	425	545	575	620	685
Outlays	395	530	550	595	655
Year end protection on deductible payments:					
Budget authority	0	9	10	11	12
Outlays	0	9	10	11	12
Changing blood deductible requirements from 3 per spell to 3 a year:					
Budget authority	6	8	10	10	11
Outlays	5	8	10	10	11
Skilled Nursing Facility Benefits:					
Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year:					
Budget authority	195	300	340	375	410
Outlays	175	285	325	360	395
Eliminating the prior hospitalization requirement for coverage of SNF stays:					
Budget authority	40	50	60	70	80
Outlays	35	50	55	65	75
Home Health Benefits:					
Extending home health benefits to 21 consecutive days:					
Budget authority	4	5	5	5	5
Outlays	4	5	5	5	5
Extending home health benefits to 45 consecutive days for enrollees with an inpatient or SNF discharge in the preceding 30 days:					
Budget authority	125	185	215	245	280
Outlays	115	175	205	235	270

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Hospice Benefits:					
Eliminating the 210 days limit on hospice benefits:					
Budget authority	(1)	1	1	1	1
Outlays	(1)	1	1	1	1
Copayment Cap:					
Capping copayments under Parts A and B combined:					
Budget authority	400	1,805	2,845	3,525	4,240
Outlays	176	1,622	2,704	3,368	4,056
Counting costs of immunosuppressive drugs toward the cap:					
Budget authority	5	20	25	30	45
Outlays	5	20	25	30	40
Counting costs of certain screening exams toward the cap:					
Budget authority	(1)	20	30	40	45
Outlays	(1)	20	30	40	45
Part B Premiums:					
Increasing flat premium:					
Budget authority	−760	−1,685	−1,945	−2,285	−2,655
Outlays	−760	−1,685	−1,945	−2,285	−2,655
Imposing an income-related supplemental premium: [2]					
Budget authority	−660	−2,300	−2,660	−3,135	−3,620
Outlays	−660	−2,300	−2,660	−3,135	−3,620
Medicaid Savings:					
Effects of Medicare provisions on federal Medicaid costs:					
Budget authority	−75	−205	−300	−360	−420
Outlays	−75	−205	−300	−360	−420
Medicaid Benefits:					
Requiring state Medicaid programs to use savings to expand benefits:					
Budget authority	10	145	290	295	65
Outlays	10	145	290	295	65
Total, Direct Spending/Offsetting Receipts:					
Budget authority	250	−272	441	482	334
Outlays	−100	−535	210	230	35
AMOUNTS SUBJECT TO APPROPRIATIONS					
Administrative costs to implement copayment cap: Outlays	60	20	20	20	20
Annual notice to enrollees of benefits under Medicare: Outlays	4	4	4	4	4
Prescription drug study: Outlays	1	0	0	0	0
Long-term care study: Outlays	2	0	0	0	0
Case management demonstration: Outlays	2	0	0	0	0
Total, Amounts Subject to Appropriations: Outlays	69	24	24	24	24
Total:					
Budget authority	160	−177	441	482	334
Outlays	−31	−511	234	254	59

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[1] Less than $0.5 million.

[2] Estimates are from the Joint Committee on Taxation.

Note: Components may not sum to total due to rounding.

The effects of this bill fall within function 570 and function 550.

BASIS OF ESTIMATE

Under current law, Part A of Medicare (Hospital Insurance) pays most of the costs for Medicare-covered services provided by hospitals, skilled nursing facilities (SNFs), home health agencies, and hospices. Enrollees share the costs of services through a variety of copayment requirements, most of which are related to the first-day hospital deductible amount (which was $520 in 1987). Part B of

Medicare (Supplementary Medical Insurance) pays for services provided by physicians, independent laboratories, and hospital outpatient departments. Under current law, SMI enrollees are responsible for the first $75 of covered medical expenses, plus 20 percent of all reasonable charges above the deductible amount.

The bill would change Medicare's copayment requirements and provide some expansion of coverage for Part B enrollees only, with the result that Medicare's reimbursement costs would increase. Over the five-year projection period, the additional Medicare benefits provided under this bill would be financed by increases in the SMI premium and by implementation of a new income-related premium collected through the income tax system. There would also be some expansion of benefits under Medicaid, financed by the Medicaid savings that the new Medicare benefits would generate.

Estimates of the costs to Medicare from the copayment provisions of this bill were derived by simulating the effects of proposed changes on a 1 percent random sample of Medicare enrollees (about 300,000 enrollee records). Medicare reimbursement and copayment costs for these enrollees in 1985 under current law were aged to 1988 through 1992, using CBO's baseline projections for enrollment and reimbursements, separately for each major service category. Total Medicare reimbursements under current law were compared to what reimbursements would be after implementation of the proposed provisions to obtain the estimated costs of the benefit expansion.

Under current law, Medicare reimbursements per enrollee are projected to increase by about 9.6 percent annually between 1987 and 1992. Under this bill, reimbursements per enrollee would increase by an estimated 10.6 percent annually over the same period. About 90 percent of the additional benefit costs would be due to the assumption by Medicare of some enrollees' copayment liabilities for current services. The remaining 10 percent of estimated costs would be due to increased use of Medicare-covered services by enrollees. The utilization responses assumed in the estimate were based on regression analyses of health care use by Medicare enrollees with and without supplementary insurance coverage for their Medicare copayment costs, using 1984 Health Insurance Survey data.

The revenue estimates for the income-related premiums were obtained from the Joint Committee on Taxation, and were based on simulations on a stratified random sample of current income tax returns, projected through 1992.

The specific provisions of the bill are explained in detail below. Unless otherwise indicated, the provisions would take effect on January 1, 1988.

DIRECT SPENDING/OFFSETTING RECEIPTS

Hospital Inpatient Benefits

The estimates in this section take account of Medicare's additional reimbursements to hospitals to compensate for Medicare enrollees' bad debt—that is, the failure by some enrollees to pay the deductible and coinsurance amounts for which they are liable. Estimates by the Inspector General of the Department of Health and

Human Services indicate that about 4 percent of enrollees' copayment liabilities for hospital stays are bad debt, which is eventually paid by Medicare.

Eliminating the limit on covered hospital days.—Under current law, Medicare will cover up to 90 days during each spell of illness, plus an additional lifetime reserve of up to 60 days. In addition, there is a lifetime reserve of 190 days for inpatient psychiatric care. This bill would eliminate the limit on covered hospital days for general care, but would retain the lifetime limit for inpatient psychiatric care.

Only a fraction of a percent of enrollees (fewer than 0.1 percent) exhaust their hospital benefits for general inpatient care each year, but the costs such patients incur are substantial. Covering these days would cost Medicare $180 million in fiscal year 1988. This estimate is based on information provided by the Health Care Financing Administration, indicating that this provision would add about 0.5 percent to total inpatient costs for Medicare-covered inpatient stays.

Eliminating enrollees' copayments for hospital coinsurance and reserve days.—Under current law, enrollees pay one-forth of the first-day hospital deductible amount for days 61–90 in a given spell of illness (coinsurance days), and one-half of the deductible amount for any lifetime reserve days used. This bill would eliminate enrollees' liability for coinsurance and reserve days. About 0.5 percent of HI enrollees use coinsurance or reserve days each year, accounting for an estimated 2.3 million coinsurance days and 0.7 million reserve days in 1988. Eliminating these inpatient coinsurance costs would cost Medicare $295 million in fiscal year 1988.

Limiting payment of the hospital deductible to the first stay each calendar year.—Under current law, enrollees are liable for a hospital deductible each time they are admitted to the hospital for a new spell of illness (which begins on the 61st day following discharge from a previous inpatient episode). In 1988, about 800,000 enrollees will pay more than one first-day deductible under current law, while no one would be liable for more than one deductible each year under this bill. In addition, the bill contains a hold-harmless provision that would protect enrollees who were readmitted after January 1, 1988, within a spell of illness that had begun prior to that date from paying another deductible for such admissions. These provisions would cost Medicare an estimated $395 million in fiscal year 1988.

Year-end protection on deductible payments.—Enrollees would be protected from having to pay a hospital deductible for admissions both in December of one year and in January of the following year. For enrollees with such an admission experience, the deductible for the January admission would be waived. Month-by-month tabulations of hospital admissions during calendar year 1985 indicate that about 0.2 percent of all enrollees with any hospital stays during the year would benefit from this provision. This would represent about 15,000 enrollees in 1989, the first year this protection would be meaningful, and would cost about $9 million in fiscal year 1989.

Changing blood deductible requirements.—Under current law, enrollees are required to replace or pay for the first 3 pints of blood used each spell of illness. This bill would require enrollees to replace or pay for the first 3 pints of blood used each year. Medicare costs would increase under this provision because enrollees would pay for an estimated 156,000 fewer pints of blood used in 1988 than they would under current law, costing Medicare about $50 per pint. The additional costs to Medicare in fiscal year 1988 would be about $5 million.

Skilled Nursing Facility Benefits

These provisions relate to Medicare coverage of stays in skilled nursing facilities (SNFs). They would change coinsurance requirements, provide for coverage of up to 150 days a year, and eliminate the 3-day prior hospitalization requirement for covered SNF care.

Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year.—The bill would alter the way in which enrollees' coinsurance liability for stays in skilled nursing facilities is determined, and would change Medicare's coverage limits from 100 days per spell to 150 days a year. Under current law, coinsurance amounts equal to one-eighth of the hospital deductible amount ($68 per day in 1988) are charged each day for days 21–100 in SNFs during each spell of illness. Under the bill, enrollees would pay coinsurance amounts equal to 15 percent of Medicare's national average reasonable cost for the first ten SNF days each year; enrollees' coinsurance costs would be an estimated $18 per day in 1988 for each coinsurance day.

Fewer than 2 percent of Medicare enrollees have covered SNF stays, but these enrollees will use about 8.6 million SNF days during 1988. These provisions would increase Medicare costs by $175 million in fiscal year 1988. About 80 percent of the costs would be due to lower coinsurance amounts paid by enrollees, while the remaining 20 percent of costs would be due to additional covered SNF days resulting from the change in coverage limits to 150 days a year. The estimate assumes that those enrollees who would exhaust their SNF coverage under current law (about 7,500 in 1988) would use the full 150 days allowed under the bill.

Eliminating the prior hospitalization requirement for SNF stays.—This bill would remove the requirement that a Medicare enrollee be hospitalized for at least three days prior to admission to a SNF to be eligible for Medicare coverage. As a result, the number of people receiving the SNF benefit would increase. Increased costs resulting from this provision are estimated at $35 million for fiscal year 1988, based on findings from a demonstration and study conducted by the Health Care Financing Administration.

Home Health Benefits

Extending home health benefits to 21 consecutive days.—Currently, Medicare enrollees are entitled to receive two to three weeks of daily home health visits. The bill would specify a limit of up to 21 days for most enrollees, and would clarify current law by specifying that "daily care" means up to 7 days a week. The estimated cost of this provision is $4 million for fiscal year 1988. The estimate is based on Medicare administrative data on the distribution of home health visits under current law, and on projections of the increased utilization that would result from clarifying the definition of daily care and increasing the limit on consecutive days.

Extending home health benefits to 45 consecutive days for enrollees following an inpatient stay.—For enrollees who had been discharged from a hospital of SNF within the previous 30 days, this bill would permit up to 45 consecutive days of care. Estimated costs of this provision are $115 million for fiscal year 1988, based on administrative data indicating the proportion of home health users with hospital stays during the year.

Hospice Benefits

The bill would eliminate the current 210-day lifetime limit on the number of days enrollees who are terminally ill may receive hospice services. Nearly 98 percent of hospice beneficiaries die before the 210-day limit is reached, but tabulations by the Health Care Financing Administration indicate that those who survive for the full 210 days of their hospice benefit live another 50 days, on average. Because not all of these additional Medicare costs under the hospice benefit would be offset by reduced costs for inpatient, SNF, or home health services, there would be a small cost due to this provision, equal to about $0.4 million in fiscal year 1988.

Copayment Cap

Each SMI enrollee's liability for copayments under Medicare would be capped at $1,700 in 1988 (but would apply only for the last half of that year). In subsequent years, the value of the copayment cap would increase at the same rate as the third-quarter Consumer Price Index (the Social Security COLA). Under CBO's baseline projections, the COLA would increase by about 4 percent annually over the five-year projection period, so that the copayment cap would be $2,014 in 1992.

About 6 percent (or 1.9 million) of enrollees would be affected by the copayment cap in 1989 (the first year the cap would be fully effective). As a result, Medicare benefit costs would increase by $1.6 billion in fiscal year 1989. By 1992, about 8 percent of enrollees would be affected by the copayment cap.

Counting costs of immunosuppressive drugs toward the copayment cap.—Under current law, Medicare covers the costs of immunosuppressive drugs in the first year following a heart or kidney transplant. This bill would permit the costs of immunosuppressive drugs after the first year to be counted toward the copayment cap (but not covered), effectively reducing the copayment cap for transplants each year. Counting the costs of immunosuppressive drugs toward the cap for the second and third years following a covered transplant would cost about $5 million in fiscal year 1988, rising to $40 million by 1992. (Medicare eligibility ceases three years after a successful transplant.)

Counting costs of certain screening tests toward the copayment cap.—Screening tests and other preventive care are not covered by Medicare under current law. The bill would permit the costs of annual colorectual examinations for enrollees age 65 or more, and of triennial mammorgrams for enrollees age 55 or more, to count toward the copayment cap. This would effectively reduce the copayment cap for enrolles who obtain such tests. About 20 percent of enrollees currently get annual colorectal examinations, and about 30 percent of female enrollees have periodic mammorgrams. No appreciate utilization increase would be expected under this provision. The estimated costs for this provision are negligible in fiscal year 1988, $20 million in 1989, and $45 million by 1992.

Part B Premiums

This bill would increase the SMI flat premium, and would impose a new supplementary income-related premium administered through the income tax system.

Increasing the flat premium.—In addition to the increases in the premium that would occur under current law to finance current SMI benefits, this bill would introduce a new flat catastrophic premium. For SMI enrollees who were also eligible for HI benefits, the monthly catastrophic premium would be set at $4 for calendar year 1988 (beginning in April of that year), indexed in subsequent years to the rate of growth in catastrophic benefits per enrollees. SMI enrollees who were not eligible for HI benefits would pay a reduced catastrophic premium (about 77 percent of the full permium), reflecting the smaller insurance value of their catastrophic benefits. This premium would generate an estimated $760 million in receipts in fiscal year 1988, offsetting part of the costs of new benefits.

Imposing an income-related supplemental premium.—SMI enrollees with income tax liability of $150 or more would also be required to pay a supplemental premium collected through the income tax system. The supplemental premium rates would be indexed to the rate of growth in catastrophic benefits per enrollees. The total amount paid would depend on each enrollee's income, up to ceiling amounts specified in the bill for each year (intended to ensure that the amount paid would not exceed 65 percent of the subsidy value of Medicare benefits).[1] In 1988, the ceiling on the supplemental premium would be $800 per SMI enrollee. Like receipts from the flat premium, these supplementary premium receipts would be earmarked for the SMI trust fund.

Medicaid Savings from New Medicare Benefits

About 9 percent of Medicare enrollees are dually eligible for Medicaid benefits. For these enrollees, Medicaid generally pays both their copayment liabilities under Medicare and their SMI premium costs. Consequently, Medicaid costs would be reduced by this bill because of lower copayment costs for dually-eligible enrollees, partially offset by increased Medicaid costs for the higher SMI flat premiums. In addition, there would be some additional savings to Medicaid in states with "medically needy" programs because the copayment limitations provided under this bill would reduce the number of Medicare enrollees who would qualify for Medicaid benefits under such programs. Savings are estimated to be $75 million in fiscal year 1988.

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[1] The subsidy value is that portion of Medicare's insurance value that is not paid by enrollees either by prior payroll tax contributions or by premiums.

Medicaid Benefits

This bill would require that states use the Medicaid savings generated by the new Medicare benefits to expand certain Medicaid benefits, for a minimum of 12 quarters. In some states, there would be a lag between receipt of the Medicaid savings and spending for new benefits because such spending would require state legislation. All Medicaid savings for the first three years would be spent by the end of the fifth year in each state, though. Medicaid benefits would increase by an estimated $10 million in fiscal year 1988, rising to a maximum of $295 million in fiscal year 1991, and falling to $65 million in 1992.

AMOUNTS SUBJECT TO APPROPRIATIONS

Administrative Costs of Copayment Cap

Neither Medicare carriers nor the Health Care Financing Administration currently collect information on the amounts of coinsurance paid by enrollees for Part B benefits. To implement the copayment cap proposed in this bill, comprehensive information about both deductible and coinsurance amounts paid under both Parts A and B would have to be compiled across all Medicare carriers for each SMI enrollee. The estimates of start-up and ongoing administrative costs under this proposal are based on discussions with the Bureau of Program Operations in the Health Care Financing Administration.

Annual Notice to Enrollees of Benefits

Under this provision, the Department of Health and Human Services would be required annually to mail each HI or SMI enrollee an explanation of Medicare benefits, beginning with calendar year 1988. Estimated costs for this provision are $4 million annually, based on previous experience with such mailings by the Social Security Administration and by the Health Care Financing Administration.

Studies and Demonstrations

This bill would mandate two studies and one demonstration that would have cost implications. Funding would be provided to the Institute of Medicine to identify additional prescription drugs that might appropriately be either covered by Medicare or counted toward the copayment cap. The Institute would also be funded for a study to explore various private- and public-sector approaches to improving provisions for long-term care. These two studies would cost an estimated $4 million in fiscal year 1988.

The Department of Health and Human Services would be provided with an additional $2 million in fiscal year 1988 to establish six demonstration projects under which peer review organizations would provide case management services to Medicare enrollees with selected catastrophic illnesses.

6. Estimated savings to State and local governments: This bill would have an effect on state and local government budgets, because of the savings that would accrue to state Medicaid programs from the new Medicare benefits and because of the requirement

that states use those savings to expand Medicaid benefits. The net effect is shown below.

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Effects on State/local Medicaid costs	−50	−50	−10	−55	−290

7. Estimate comparison: None.
8. Previous CBO estimates: None.
9. Estimate prepared by: Sandra Christensen, Holly Harvey, Don Muse.
10. Estimate approved by: James L. Blum, Assistant Director for Budget Analysis.

VI. REGULATORY IMPACT

Pursuant to paragraph 11(b) of Rule XVI of the Standing Rules of the Senate, the Committee makes the following statement concerning the regulatory impact that might be incurred in carrying out S. 1127 as amended by the Committee.

A. Numbers of Individuals and Businesses Who Would Be Regulated

The bill does not change the numbers of individuals or businesses who would be regulated.

B. Economic Impact of Regulation on Individuals, Consumers, and Business

The bill expands Medicare coverage to cover many expenses currently paid by beneficiaries, either directly or through private supplemental insurance. Beneficiaries will thus be relieved of these financial liabilities. To finance this expanded coverage, all beneficiaries will be required to pay an additional basic monthly premium and some beneficiaries will be required to pay an income-related supplemental premium. The bill will affect consumers who purchase private supplemental insurance by covering under Medicare many of the services now covered by these policies. The bill will likewise affect the business of private supplemental insurance by eliminating some of the beneficiary liability now covered under private policies. Section 13 also changes the standards for voluntary certification of private supplemental policies.

C. Impact on Personal Privacy

The bill does not generally relate to the personal privacy of individuals.

D. Determination of the Amount of Paperwork

Section 9 of the bill adds a requirement for notification to Medicare beneficiaries concerning Medicare coverage. Section 6 of the bill requires notice to beneficiaries of the number of months for which they were enrolled in Part B, and will also necessitate changes in income tax forms and instructions.

VII. ADDITIONAL VIEWS OF MR. WALLOP

As the members of the Finance Committee were approving the catastrophic health insurance bill, S. 1127, the euphoria of this action distracted most members from noticing that the legendary camel was sticking his nose underneath the tent. Indeed, there never has been a larger camel's nose. While dealing with a problem 22 years late, we are building a fabulous new load on the Medicare program, and it may be that last straw that broke the camel's back (in this case, the self-financing Medicare program).

The Chairman of our Committee did a commendable job putting together an Acute Care Health Insurance Program for our retired and disabled citizens. The Committee withstood the pressure to rapidly expand its scope and, worse still, the cost of the program. It is frightening to think what will happen when this bill reaches the floor of the Senate. We side-stepped several blockbuster amendments only by agreeing that these matters will be considered during the Senate's debate or as amendments to other legislation (such as the Budget Reconciliation bill). However, there is a variety of groups and some too willing Senators who are interested in expanding this legislation into a prototype for comprehensive national health insurance.

Just as the Finance Committee was unanimous in reporting this bill, members should also present a united front in rejecting these expansionist inclinations which would destroy what is now a reasonable bill.

The history of the Social Security Act, which includes the Medicare program as Title XVIII, is one of benefit expansion. Over the 52 years of the Act's existence, the Congress has expanded benefits and has expanded the taxes to fund them. Usually, the expanded taxes have lagged behind the new benefits. The strategy has been to argue that some additional benefit is necessary or some group requires coverage under one or more titles of the Act. The cost is minimized. Once the benefit is enacted, then the Social Security Administration actuaries report that the Social Security trust funds are in danger of being bankrupted by the most recent expansion. So, we inevitably expand the taxes rather than review the new demands. Or, in the case of Medicare's Part B premium, we expand the use of General Revenues, which really means enlarging the federal budget deficit.

The Medicare program was enacted with one specific mission. Its task was to provide, on a cost-sharing basis with beneficiaries, insurance coverage for acute care hospital and physician services. It can be argued that the original focus of Medicare should have been on protecting the elderly from health care catastrophies rather than short term acute care. That is a concept we have been trying to catch up with since 1965.

Three funding sources were created for this federal acute care insurance. The hospital services, which have accounted for two thirds of program costs, are funded by a payroll tax. Physician services are funded by participants' premiums and general revenues. When Medicare became law in 1965, it was proclaimed to be on sound financial footing. The program cost $64 million in its first year. Just two years later, the cost quadrupled to $4.7 billion. The program was in trouble, and payroll taxes were increased. Five years later, another, substantial, increase in taxes was enacted. The cost of Medicare has constantly exceeded projections. By the time we reached the 20th anniversary of the program, the costs were about eight times the original projections by the program actuaries. When President Reagan took office in 1981, Medicare cost $32 billion. This year, the cost will have more than doubled, to $73 billion. While program costs were understated by proponents to ensure passage of the original legislation, there was also a failure to truly appreciate actual cost of benefits. We may fall into that same trap with this new coverage.

The Congress has previously expanded benefits with costly results. For instance, in 1972, coverage was provided to the disabled and those receiving kidney dialysis (ESRD). Since a disabled beneficiary, on average, has costs about 30 percent higher than retired beneficiaries, this coverage increased costs well beyond the simple increase in participants. The ESRD benefit had an explosive and unexpected price tag. We have reined in the ESRD benefit, but only because we were forced to do so through the budget reconciliation process.

Now, we are about to provide the second major expansion of the program. Make no mistake, this is an expansion of benefits rather than participants. Many have mislabeled our legislation as a catastrophic health insurance bill. Such a label suggests that whenever a beneficiary experiences an illness requiring high cost medical care, this catastrophic insurance will pay for such care. That is the objective of those who preach an expansionist view of the Social Security program. It may be the expectation of those who take our title at face value. It will become the demand of politics and expectation.

S. 1127 does not, I repeat does not, provide catastrophic health insurance. It is simply a fill-in of the holes left in the acute care insurance that is Medicare. Medicare has cost sharing and deductibles for every length of stay in a hospital. Medicare also has a limit on the number of days in a hospital covered by this insurance. The Committee bill expands Medicare to provide unlimited days of stay in a hospital for an illness and limits the out of pocket payments by participants to the hospital and physician for their care. It is an extended acute care benefit, not a catastrophic health package.

Two points need to be emphasized. First, the expanded benefit preempts private Medigap policies which provided similar health insurance coverage. About 70 percent of Medicare beneficiaries now have this private insurance. This insurance provided by the marketplace will be eliminated in return for insurance provided by the federal government. Of those who had no Medigap insurance, about half are covered by Medicare. Thus, this legislation ultimately benefits only about 10 percent of the population who are not covered by Medicaid and have not purchased Medigap insurance. This legislation will not improve benefit coverage for most Medicare participants. Only about 3 percent of those covered by Medicare will actually utilize this benefit in any one year.

The second point is that this benefit is related to a hospital stay based on illness. Many Medicare beneficiaries now believe that Medicare provides a full range of health benefits, even to include nursing home care. That is a misconception which will be further enhanced by this misnamed "catastrophic" health insurance bill. Medicare only covers about 44 percent of the health care costs of the elderly. It does not cover prescription drugs, dental services, many mental health services, nor does it cover custodial care in a nursing home. This bill will not cover any of those services either. These are the types of services the expansionists want Medicare to provide. They want to totally replace individual responsibility and the private marketplace with government-provided care. And the cost—well, they don't worry about the cost. It can be financed by deficit spending or higher taxes.

Now that the federal government will be committed to cover the cost of catastrophic illness, no limiting principle will define the proper role of government in providing health care. Future debates will involve how to make federal catastrophic care more comprehensive.

The bill considered by the House of Representatives has a prescription drug benefit tailing along. It would be funded by higher taxes (through increased premiums), but would have a $3 billion estimated deficit in just eight years. This would be covered by deficit spending, rhetoric on deficits notwithstanding. Long term nursing care is projected to cost between $30 and $50 billion. The premium to finance such a benefit would be astronomical.

The financing of S. 1127 will present a real challenge to fiscal responsibility. I fear the proposed financing mechanisms will prove to be inadequate to support future benefit costs. While the program costs are directly linked to premiums, as costs escalate, this linkage could be severed. Unfortunately, we already have a precedent with the Part B premium for shifting costs to General Revenues.

It is this same Part B Premium which is used to finance the new benefit. The basic premium would be increased, and a new supplemental premium, labeled a "means test," is added. Means tests are traditionally used to limit access. This supplemental premium is used to shift costs on an intragenerational basis. It is actually a progressive tax which reflects redistributive tendencies of the Congress. And, if both premiums fail to fund this benefit, we will undoubtedly revert to old habits and use General Revenues to fund Part B services.

Our ability to resist financing through General Revenues is usually found wanting, as demonstrated by past decisions to let the Part B Premium slip. Using general revenues, rather than user fees, is always a tempting political solution for providing new government services. Since the passage of the Social Security Act, there has been an effort to fund part of the entire program—retirement benefits as well health benefits—through General Revenues.

It is not surprising that General Revenue financing is again a prospect. But, it would be wrong to allow this provision to break with self-financing and budget neutrality. I would hope that the principle of the user pays would not be violated in this legislation, but this camel's nose like Pinocchio's is predicted to grow.

The Committee has decided that this is an appropriate direction for federal health care policy. But, how do we constrain this new endeavor? Will we have reasonable and meaningful limitations on the scope of federal catastrophic care? Will we continue to recognize private insurance and savings as the bulwark of health care financing? Will we allow health care expenditures to absorb more and more of our GNP? We hope that the 100th Congress will have the correct responses to these questions.

As was demonstrated during our Committee's discussions, S. 1127 opens up a far reaching ethical, social and economic debate. That is the question of the extent to which we, as a society, will provide whatever care is necessary to prolong life. This debate was broached by a very brief discussion of the treatment of those who suffer from AIDS. It was also recently raised by the recent HCFA regulations for Medicare coverage of heart transplants. The fundamental question is whether through public policy (and public financing) we will provide whatever health care people demand regardless of cost.

What type of limits, formal and informal, will we place on health services? That is a debate we will have to face some day soon. It will most likely be one of the most difficult issues ever confronted by the Congress. The camel lying behind the nose is the expectation created that each American has the right, almost theological in its dimension, to the full scientific ability of the world to prolong his life and comfort regardless of cost. From organ transplants to mechanical transplants, from exotic rare procedures to experimental science, citizens will expect and politicians may respond.

I would like to reiterate a recent statement by Dr. Bowen. It is a challenge to design an acute care benefit that is affordable to beneficiary, taxpayer and government alike—a program that needs no new taxes, no new bureaucracy, is budget neutral and does not exacerbate the deficit or problems of the Medicare trust funds. The Finance Committee bill does a respectable job of meeting this challenge. Adding unrelated baggage during Senate debate or adopting provisions in the House bill in Conference would most likely sink this proposal or the country. The Senate, in this bicentennial session, has yet to demonstrate that as a body it is committed to fiscal responsibility. Our actions on S. 1127 will demonstrate how serious we are about legislating in a responsible fashion.

MALCOLM WALLOP.

VIII. ADDITIONAL VIEWS OF MR. ARMSTRONG

In some respects, S. 1127 is about 22 years late. A good case can be made that the most appropriate Federal health care program from the start would have been one to protect the elderly from catastrophic illness rather than the kind of short term acute care costs routinely incurred in hospitals. Now, after spending over $500 billion since 1965 on acute care, Congress is ready to implement some measure of catastrophic protection.

S. 1127, as reported, is a reasonable response to President Reagan's catastrophic care proposal. But before the Senate enacts the bill, or significantly expand its scope, I hope my colleagues will reflect on several potential concerns.

First, once the Federal Government makes a commitment to cover the cost of "catastrophic" illness, no limiting principle will exist to define its proper role in providing health care. In the years ahead, the debate will be on how to make catastrophic care more comprehensive. The burden that individuals and private insurance should bear in providing for health care needs is apt to be given less consideration. In short, the legislation holds out the prospect of an ever-expanding Federal role in health insurance.

It's no great mystery why this might occur. Many Medicare beneficiaries already expect the program to provide a full range of benefits. S. 1127, though bearing the label of "catastrophic" care, retains the present focus of Medicare on acute ailments. As has been well noted, the bill does not address the true source of catastrophic costs, such as long term nursing care which is now prohibitively expensive. Pressure will surely mount to move catastrophic care in this direction.

Second, even if catastrophic care were limited to the reasonable provisions of S. 1127, I have great confidence in Congress' ability to underestimate the program's cost. Last year, health care inflation exceeded the increase in consumer prices by a 7 to 1 ratio last year. That fact, combined with increased utilization due to an aging population and the development of new and expensive medical technology, may conspire to increase costs well beyond what Congress anticipates today.

Proposed financing mechanisms are unlikely to prove adequate to support future benefit costs. While a direct premium linked to costs is sensible, Congress will quickly end that linkage when costs start to escalate. It's also unlikely beneficiaries will easily accept the euphemism of the so-called "supplemental premium." It is really a progressive tax (did someone say "means-test"?) on some to pay for the catastrophic benefits of others. That is not "insurance", but the usual benefit redistribution scheme Congress is adept at establishing. The fact the transfer is "intragenerational" sounds equitable, but Congress will face strenuous pressure to control it.

History supports these concerns. Medicare was created in 1966, supposedly on a sound footing. The program cost $64 million that year. Just 2 years later, the cost quadrupled to $4.7 billion and, in the face of financial trouble, payroll taxes were increased. Five years later, they were increased again. The cost of Medicare has constantly exceeded projections. At its 20 year anniversary, the program was eight times its original projections. When President Reagan took office in 1981, Medicare cost $32 billion. This year, the cost will be more than double that, $73 billion. By 1990, the program will exceed $100 billion. Congress has clearly demonstrated its inability to control Medicare expenditure, and will probably do so again.

The result, in the not too distant future, will be as follows: catastrophic care payments will greatly exceed expectations and revenues will fall short. The HI trust fund, which already faces bankruptcy in the 1990s, will suffer further, along with the overall Federal budget deficit.

But once this program assumes its inevitable sacred cow status, they'll be little chance of curbing benefits. Any move to control costs will likely involve more extensive Federal control and regulation of providers than exists even today. There will also be considerable pressure to raise revenues from any source—payroll taxes, general revenues, excise taxes—to pay for benefits. When that occurs, the hope this program would remain self-financing and budget neutral will fade away.

Indeed, to some extent, the concept of budget neutrality is already irrelevant: it's easy to propose spending and taxes at equally higher levels. Even if Congress finds a way to keep the program self-financing, the Federal Government will end up consuming substantially more private resources—bad news for Americans trying to save money for health care needs. Ultimately, not only might this initiative end up supplanting existing private Medigap policies, which now cover Medicare copayments, it might also establish disincentives for private savings and insurance to cover health care needs.

Congress should carefully consider whether this is an appropriate direction for Federal health care policy and whether reasonable and meaningful limits on the scope of Federal catastrophic care should be put in place. Congress should also continue to promote private insurance and savings as the principle means of health care financing in this country. Otherwise, our Nation may be heading down a road of vast expenditures, vast taxation, and excessive regulation with potentially ruinous consequences on our Nation's health care industry.

Again, history is instructive. Since 1965, the Federal Government has spent $517 billion on Medicare and another $346 billion on other Federal health care programs. From 1987 to 1992, another $602 billion will be spent on Medicare and $302 billion on other health care under existing reimbursement policies. What have we gotten for the $850 billion spent over the last 20 years? What will we get for the $900 billion that would be spent by 1992 even without this bill? Many elderly citzens have far greater access to health care than in 1965, and that is surely a great accomplishment. But it is clear the Nation has faced rampant inflation in health care, largely driven by Federal expenditures and reimbursement policies, and gained a huge health care regulatory bureaucracy on which hospitals and doctors have become ensnared and dependent.

The Federal Government can play a positive role in providing for the catastrophic health care needs of our citizens. Congress should also preserve and cultivate an expanding private role in protecting Americans from catastrophic illness and in encouraging individuals to plan and save for their health care needs. This legislation is well intentioned and, thus far at least, reasonably crafted. But it holds the seeds of its own destruction. I hope my colleagues will carefully consider these concerns as the Senate debates this measure and amendments to greatly expand its scope.

WILLIAM ARMSTRONG.

IX. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

Pursuant to the requirements of paragraph 12 of Rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill S. 1127, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

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TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

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[PROGRAM FOR DETERMINING QUALIFICATIONS FOR CERTAIN HEALTH CARE PERSONNEL

[SEC. 1123. (a) The Secretary, in carrying out his functions relating to the qualifications for health care personnel under title XVIII, shall develop (in consultation with appropriate professional health organizations and State health and licensure agencies) and conduct (in conjunction with State health and licensure agencies) until September 30, 1987, a program designed to determine the proficiency of individuals (who do not otherwise meet the formal educational, professional membership, or other specific criteria established for determining the qualifications of practical nurses, therapists, laboratory technicians, and technologists, and cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists) to perform the duties and functions of practical nurses, therapists, laboratory technichians, technologists, and cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists. Such program shall include (but not be limited to) the employment of procedures for the formal testing of the proficiency of individuals. In the conduct of such program, no individual who otherwise meets the proficiency requirements for any health care specialty shall be denied a satisfactory proficiency rating solely because of his failure to meet formal educational or professional membership requirements.

[(b) If any individual has been determined, under the program established pursuant to subsection (a), to be qualified to perform the duties and functions of any health care specialty, no person or provider utilizing the services of such individual to perform such duties and functions shall be denied payment, under title XVIII or under any State plan approved under title XIX, for any health care services provided by such person on the grounds that such individual is not qualified to perform such duties and functions.]

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

DESCRIPTION OF PROGRAM

SEC. 1811. The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of hospital, [related post-hospital] *extended care services,* home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under title II of this Act (or would be eligible for such benefits if certain government employment were covered employment under such title) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of this Act (or would have been so entitled to such benefits if certain government employment were covered employment under such title) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

[SCOPE OF BENEFITS

[SEC. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

[(1) inpatient hospital services for up to 150 days during any spell of illness minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

[(2)(A) post-hospital extended care services for up to 100 days during any spell of illness, and (B) to the extent provided in subsection (f), extended care services that are not post-hospital extended care services;

[(3) home health services; and

[(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each [and one subsequent period of 30 days], *a subsequent period of 30 days, and a subsequent extension period* with respect to which the individual makes an election under subsection (d)(1).

[(b) Payment under this part for services furnished an individual during a spell of illness may not (subject to subsection (c)) be made for—

[(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

[(2) post-hospital extended care services furnished to him during such spell after such services have been furnished to him for 100 days during such spell; or

[(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

[(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3)).

[(d)(1) Payment under this part may be made for hospice care provided with respect to an individual only during two periods of 90 days each [and one subsequent period of 30 days], *a subsequent period of 30 days, and a subsequent extension period* during the individual's lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care under this part provided by, or under arrangements made by, a particular hospice program instead of certain other benefits under this title.

[(2)(A) Except as provided in subparagraphs (B) and (C) and except in such exceptional and unusual circumstances as the Secretary may provide, if an individual makes such an election for a period with respect to a particular hospice program, the individual shall be deemed to have waived all rights to have payment made under this title with respect to—

[(i) hospice care provided by another hospice program (other than under arrangements made by the particular hospice program) during the period, and

[(ii) services furnished during the period that are determined (in accordance with guidelines of the Secretary) to be—

[(I) related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made or

[(II) equivalent to (or duplicative of) hospice care;

except that clause (ii) shall not apply to physicians' services furnished by the individual's attending physician (if not an employee of the hospice program) or to services provided by (or under arrangements made by) the hospice program.

[(B) After an individual makes such an election with respect to a 90- or 30-day period *or a subsequent extension period*, the individual may revoke the election during the period, in which case—

[(i) the revocation shall act as a waiver of the right to have payment made under this part for any hospice care benefits for the remaining time in such period and (for purposes of subsection (a)(4) and subparagraph (A)) the individual shall be deemed to have been provided such benefits during such entire period, and

[(ii) the individual may at any time after the revocation execute a new election for a subsequent period, if the individual otherwise is entitled to hospice care benefits with respect to such a period.

[(C) An individual may, once in each such period, change the hospice program with respect to which the election is made and such change shall not be considered a revocation of an election under subparagraph (B).

[(D) For purposes of this title, an individual's election with respect to a hospice program shall no longer be considered to be in effect with respect to that hospice program after the date the individual's revocation or change of election with respect to that election takes effect.

[(e) For purposes of subsections (b) and (c), in patient hospital services, inpatient psychiatric hospital services, and post-hospital extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

[(f)(1) The Secretary shall provide for coverage, under clause (B) of subsection (a)(2), of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this title and will not alter the acute care nature of the benefit described in subsection (a)(2).

[(2) The Secretary may provide—

[(A) for such limitations on the scope and extent of services described in subsection (a)(2)(B) and on the categories of individuals who may be eligible to receive such services, and

[(B) notwithstanding sections 1814, 1861(v), and 1886, for such restrictions and alternatives on the amounts and methods of payment for services described in such subsection,

as may be necessary to carry out paragraph (1).

[(g) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.

SCOPE OF BENEFITS FOR INDIVIDUALS COVERED UNDER PARTS A AND B

SEC. 1812. (a) The benefits provided by the insurance program under this part to an individual who is covered by such program and by the insurance program under part B shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services;

(2) extended care services for up to 150 days during any calendar year;

(3) home health services; and

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each [and one subsequent period of 30 days], a subsequent period of 30 days, and a subsequent extension period with respect to which the individual makes an election under subsection (c)(1).

(b) Payment under this part for services furnished to an individual who is covered by the insurance programs established under this part and part B may not be made for—

(1) extended care services furnished to him during a calendar year after such services have been furnished to him for 150 days during that year; or

(2) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

(c)(1) Payment under this part may be made for hospice care provided with respect to an individual only during two periods of 90 days each and one subsequent period of 30 days during the individual's lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care under this part provided by, or under arrangements made by, a particular hospice program instead of certain other benefits under this title.

(2)(A) Except as provided in subparagraphs (B) and (C) and except in such exceptional and unusual circumstances as the Secretary may provide, if an individual makes such an election for a period with respect to a particular hospice program, the individual shall be deemed to have waived all rights to have payment made under this title with respect to—

(i) hospice care provided by another hospice program (other than under arrangements made by the particular hospice program) during the period, and

(ii) services furnished during the period that are determined (in accordance with guidelines of the Secretary) to be—

(I) related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made, or

(II) equivalent to (or duplicative of) hospice care;

except that clause (ii) shall not apply to physicians' services furnished by the individual's attending physician (if not an employee of the hospice program) or to services provided by (or under arrangements made by) the hospice program.

(B) After an individual makes such an election with respect to a 90- or 30-day period, the individual may revoke the election during the period, in which case—

(i) the revocation shall act as a waiver of the right to have payment made under this part for any hospice care benefits for the remaining time in such period and (for purposes of subparagraph (A), subsection (a)(4), and section 1812A(a)(4)) the individual shall be deemed to have been provided such benefits during such entire period, and

(ii) the individual may at any time after the revocation execute a new election for a subsequent period, if the individual otherwise is entitled to hospice care benefits with respect to such a period.

(C) An individual may, once in each such period, change the hospice program with respect to which election is made and such change shall not be considered a revocation of an election under subparagraph (B).

(D) For purposes of this title, an individual's election with respect to a hospice program shall no longer be considered to be in effect with respect to that hospice program after the date the individual's revocation or change of election with respect to that election takes effect.

(d) For purposes of subsection (b), inpatient psychiatric hospital services and extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

SCOPE OF BENEFITS FOR INDIVIDUALS COVERED UNDER PART A ONLY

SEC. 1812A. (a) The benefits provided by the insurance program under this part to an individual who is covered by such program but not by the insurance program under part B shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless the individual specifies in accordance with regulations of the Secretary that the individual does not desire to have such payment made);

(2)(A) post-hospital extended care services for up to 100 days during any spell of illness, and (B) to the extent provided in subsection (f), extended care services that are not post-hospital extended care services;

(3) home health services; and

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each [*and one subsequent period of 30 days*]*, a subsequent period of 30 days, and a subsequent extension period with respect to which the individual makes an election under section 1812(c)(1).*

(b) Payment under this part for services furnished during a spell of illness to an individual who is covered by the insurance program under this part but not by the insurance program under part B may not (subject to subsection (c)) be made for—

(1) inpatient hospital services furnished to the individual during such spell after such services have been furnished to the individual for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 days received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services furnished to the individual during such spell after such services have been furnished to the individual for 100 days during such spell; or

(3) inpatient psychiatric hospital services furnished to the individual after such services have been furnished to the individual for a total of 190 days during the lifetime of the individual.

(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3)).

(d) The provisions of section 1812(c) shall apply to individuals who are covered by the insurance program under this part but not by the insurance program under part B in the same manner and to the same extent as those provisions apply to individuals who are covered under both such programs.

(e) For purposes of subsections (b) and (c), inpatient hospital services, inpatient psychiatric hospital services, and post-hospital extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

(f)(1) The Secretary shall provide for coverage, under subsection (a)(2)(B), of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this title and will not alter the acute care nature of the benefit described in subsection (a)(2).

(2) The Secretary may provide—

(A) for such limitations on the scope and extent of services described in subsection (a)(2)(B) and on the categories of individuals who may be eligible to receive such services, and

(B) notwithstanding sections 1814, 1861(v), and 1886, for such restrictions and alternatives on the amounts and methods of payment for services described in such subsection,

as may be necessary to carry out paragraph (1).

[DEDUCTIBLES AND COINSURANCE

[SEC. 1813. (a)(1) The amount payable for inpatient hospital services furnished an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to—

[(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is funished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

[(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812(a)(1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).

[(2) The amount payable to any provider of services under this part for services furnished an individual during any spell of illness shall be further reduced by a deduction equal to the cost of the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during such spell of illness.

[(3) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.

[(4)(A) The amount payable for hospice care shall be reduced—

[(i) in the case of drugs and biologicals provided on an outpatient basis by (or under arrangements made by) the hospice program, by a coinsurance amount equal to an amount (not to exceed $5 per prescription) determined in accordance with a drug copayment schedule (established by the hospice program) which is related to, and approximates 5 percent of, the cost of the drug or biological to the program, and

[(ii) in the case of respite care provided by (or under arrangements made by) the hospice program, by a coinsurance amount equal to 5 percent of the amount estimated by the hospice program (in accordance with regulations of the Secretary) to be equal to the amount of payment under section 1814(i) to that program for respite care;

except that the total of the coinsurance required under clause (ii) for an individual may not exceed for a hospice coinsurance period the inpatient hospital deductible applicable for the year in which the period began. For purposes of this subparagraph, the term "hospice coinsurance period" means, for an individual, a period of consecutive days beginning with the first day for which an election under section 1812(d) is in effect for the individual and ending with the close of the first period of 14 consecutive days on each of which such an election is not in effect for the individual.

[(B) During the period of election by an individual under section 1812(d)(1), no copayments or deductibles other than those under subparagraph (A) shall apply with respect to services furnished to such individual which constitute hospice care, regardless of the setting in which such services are furnished.

[(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the applicable percentage increase (as defined in section 1886(b)(3)(B)) which is applied under section 1886(d)(3)(A) for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher multiple of $4).

[(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

[(3) The inpatient hospital deductible for a year shall apply to—

[(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services occurs in a spell of illness, and

[(B) to the coinsurance amounts under subsection (a) for inpatient hospital services and post-hospital extended care services furnished in that year.]

DEDUCTIBLES AND COINSURANCE FOR INDIVIDUALS COVERED UNDER PARTS A AND B

SEC. 1813. (a)(1)(A) Subject to subparagraph (C), the amount payable for inpatient hospital services furnished to an individual who is covered by the insurance programs under this part and part B during the individual's first period of hospitalization to begin during a calendar year shall be reduced by a deduction equal to the inpatient hospital deductible for that year or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the *charges so imposed, such customary charges shall be considered to be the charges so imposed.*

(B) For purposes of subparagraph (A), the term "period of hospitalization" means, with respect to an individual, the period beginning on the first day the individual is furnished inpatient hospital services and ending on the individual's date of discharge (as established by the Secretary for purposes of section 1886) from the hospital (or, in the case of a transfer, hospitals) involved.

(C) In the case of an individual with respect to whom—

(i) a period of hospitalization begins during December of any calendar year,

(ii) an inpatient hospital deductible is imposed with respect to such period of hospitalization, and

(iii) a period of hospitalization begins during January of the following calendar year,

no inpatient hospital deductible shall be imposed with respect to a period of hospitalization beginning in January of such following year (and such period of hospitalization shall not be taken into account in determining the application of an inpatient hospital deductible to any period of hospitalization beginning for such individual after January 31 of such following year).

(2) The amount payable to any provider of services under this part for services furnished during any calendar year to an individual who is covered by the programs established under this part and part B shall be further reduced by a deduction equal to the cost of the first 3 pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during that year.

(3)(A) The amount payable for extended care services furnished in any calendar year to an individual who is covered by the insurance programs established under this part and part B shall be reduced by the coinsurance amount (promulgated under subparagraph (C) for that year) for each of the first 10 days on which he is furnished such services during any stay in a skilled nursing facility, but in no event shall a coinsurance amount be imposed under this paragraph with respect to an individual for more than 10 days in any calendar year.

(B) Before September 1 of each year (beginning with 1987), the Secretary shall estimate the national average per diem reasonable cost recognized under this title for extended care services that will be furnished in the succeeding calendar year.

(C) The Secretary shall, in September of each year (beginning with 1987) promulgate the coinsurance amount that shall apply to extended care services furnished in the succeeding year. Such amount shall be equal to 15 percent of the national average per diem cost estimated under subparagraph (B) for that year. If the coinsurance amount determined under the preceding sentence is not a multiple of $1, it shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(4)(A) The amount payable for hospice care shall be reduced—

(i) in the case of drugs and biologicals provided on an outpatient basis by (or under arrangements made by) the hospice program, by a coinsurance amount equal to an amount (not to

exceed $5 per prescription) determined in accordance with a drug copayment schedule (established by the hospice program) which is related to, and approximates 5 percent of, the cost of the drug or biological to the program, and

(ii) in the case of respite care provided by (or under arrangements made by) the hospice program, by a coinsurance amount equal to 5 percent of the amount estimated by the hospice program (in accordance with regulations of the Secretary) to be equal to the amount of payment under section 1814(i) to that program for respite care;

except that the total of the coinsurance required under clause (ii) for an individual may not exceed for a hospice coinsurance period the inpatient hospital deductible applicable for the year in which the period began. For purposes of this subparagraph, the term "hospice coinsurance period" means, for an individual, a period of consecutive days beginning with the first day for which an election under section 1812(c) is in effect for the individual and ending with the close of the first period of 14 consecutive days on each of which such an election is not in effect for the individual.

(B) During the period of an election by an individual under section 1812(c)(1), no copayments or deductibles other than those under subparagraph (A) shall apply with respect to services furnished to such individual which constitute hospice care, regardless of the setting in which such services are furnished.

(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the applicable percentage increase (as defined in section 1886(b)(3)(B)) which is applied under section 1886(d)(3)(A) for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, the next higher multiple of $4).

(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

DEDUCTIBLES AND COINSURANCE AMOUNTS FOR INDIVIDUALS COVERED UNDER PART A ONLY

SEC. 1813A. (a)(1) The amount payable for inpatient hospital services furnished during any spell of illness to an individual who is covered by the insurance program under this part but not by the insurance program under part B shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to—

(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812A(a)(1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).

(2) The amount payable to any provider of services under this part for services furnished during any spell of illness to an individual who is covered by the insurance program under this part but not by the insurance program under part B shall be further reduced by a deduction equal to the cost of the first 3 pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during such spell of illness.

(3) The amount payable for post-hospital extended care services furnished during any spell of illness to an individual who is covered by the insurance program under this part but not by the insurance program under part B shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which the individual is furnished such services after such services have been furnished to the individual for 20 days during such spell.

(b) The provisions of section 1813(a)(4) shall apply to individuals who are covered by the insurance program under this part but not by the insurance program under part B in the same manner and to the same extent as those provisions apply to individuals covered under both such programs.

(c)(1) For purposes of this section, the "inpatient hospital deductible" for a year is the inpatient hospital deductible promulgated under section 1813 for that year.

(2) The inpatient hospital deductible for a year shall apply to—

(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services occurs in a spell of illness, and

(B) to the coinsurance amounts under subsection (a) for inpatient hospital services and post-hospital extended care services furnished in that year.

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

* * * * * * *

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

* * * * * * *

(B)(*i*) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services**[**;**]**, *and*

(ii) in the case of extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitative services, which as a practical matter can only be provided in a skilled nursing facility;

* * * * * * *

(6) with respect to inpatient hospital services, *extended care services,* or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services, *further extended care services,* or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding; and

(7) in the case of hospice care provided an individual—

(A)(i) in the first 90-day period—

(I) the individual's attending physician (as defined in section 1861(dd)(3)(B)), and

(II) the medical director (or physician member of the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program providing (or arranging for) the care,

each certify, not later than two days after hospice care is initiated, that the individual is terminally ill (as defined in section 1861(dd)(3)(A)), [and]

(ii) in a subsequent 90- or 30-day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill[;], *and*

(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;

* * * * * * *

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), or (D) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. *For purposes of paragraph (2)(C), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker) or if the indivudual has a condition such that leaving his or her home is medically contra-indicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a consid-*

erable and taxing effort by the individual, and that absences of the individual from home are infrequent or of relatively short duration.

* * * * * * *

Amount Paid to Providers

(b) The amount paid to any provider of services (other than a hospice program providing hospice care and other than a home health agency with respect to durable medical equipment) with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1813, *1813a,* and 1886, be—

* * * * * * *

Payments for Emergency Hospital Services

(d)(1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year, by the hospital or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has elected to claim payments for all such inpatient emergency services and for the emergency outpatient services referred to in section 1835(b) furnished during such year. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

(2) Payment may be made on the basis of an itemized bill to an individual entitled to hospital insurance benefits under section 226 for services described in paragraph (1) which are emergency services if (A) payment cannot be made under paragraph (1) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement.

(3) The amounts payable under the preceding paragraph with respect to services described therein shall, subject to the provisions of [section 1813] *sections 1813 and 1813A*, be equal to 60 percent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations (as defined in section 1861(v)(4)), whichever is less, plus 80 percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on two-thirds of the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. For purposes of the preceding provisions of this paragraph, the term "routine services" shall mean the regular room, dietary, and nursing services,

minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made; the term "ancillary services" shall mean those special services for which charges are customarily made in addition to routine services.

* * * * * * *

Payment for Inpatient Hospital Services Prior to Notification of Noneligibility

(e) Notwithstanding that an individual is not entitled to have payment made under this part for inpatient hospital services furnished by any hospital, payment shall be made to such hospital (unless it elects not to receive such payment or, if payment has already been made by or on behalf of such individual, fails to refund such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification to such hospital from the Secretary of his lack of entitlement, if such payments are precluded only by reason of section 1812 *or section 1812A* and if such hospital complies with the requirements of and regulations under this title with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed. Payment under the preceding sentence may not be made for services furnished an individual pursuant to any admission after the 6th elapsed day (not including as an elapsed day Saturday, Sunday, or a legal holiday) after the day on which such admission occurred.

Payment for Certain Inpatient Hospital Services Furnished Outside the United States

(f)(1) Payment shall be made for inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States, or under arrangements (as defined in section 1861(w)) with it, if—

(A) such individual is a resident of the United States, and

(B) such hospital was closer to, or substantially more accessible from, the residence of such individual than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

(2) Payment may also be made for emergency inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States if—

(A) such individual was physically present—

(i) in a place within the United States; or

(ii) at a place within Canada while traveling without unreasonable delay by the most direct route (as determined by the Secretary) between Alaska and another State;

at the time the emergency which necessitated such inpatient hospital services occurred, and

(B) such hospital was closer to, or substantially more accessible from, such place than the nearest hospital within the

United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

(3) Payment shall be made in the amount provided under subsection (b) to any hospital for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual by the hospital or under arrangements (as defined in section 1861(w)) with it if (A) the Secretary would be required to make such payment if the hospital had an agreement in effect under this title and otherwise met the conditions of payment hereunder, (B) such hospital elects to claim such payment, and (C) such hospital agrees to comply, with respect to such services, with the provisions of section 1866(a).

(4) Payment for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual entitled to hospital insurance benefits under section 226 may be made on the basis of an itemized bill to such individual if (A) payment for such services cannot be made under paragraph (3) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and continuing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amount payable with respect to such services shall, subject to the provisions of [section 1813] *sections 1813 and 1813A*, be equal to the amount which would be payable under subsection (d)(3).

* * * * * * *

FEDERAL HOSPITAL INSURANCE TRUST FUND

SEC. 1817. (a) * * *

* * * * * * *

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereafter in this section referred to as the "Managing Trustee"). The Administrator of the Health Care Financing Administration shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

* * * * * * *

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall also include *an evaluation of the extent to which the premiums collected under sections 1839(g) and section 1839A are sufficient to pay for catastrophic coverage benefits (as defined in section 1839(g)(2)(C)(i)) and related administrative expenses payable from the Trust Fund and* an actuarial opinion by the Chief Actuarial Officer of the Health Care Financing Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall be printed as a House document of the session of the Congress to which the report is made. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

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Part B—Supplementary Medical Insurance Benefits for the Aged and Disabled

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SCOPE OF BENEFITS

Sec. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2); [and]

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) * * *

* * * * * * *

(F) facility services furnished in connection with surgical procedures specified by the Secretary—

* * * * * * *

and if the physician agrees to accept the standard overhead amount determined under section 1833(i)(2)(B) as full payment for such services and to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with such surgical procedure to individuals enrolled under this part[.]*; and*

(3) entitlement to have payment made to him or on his behalf (subject to the provisions of this title) for any catastrophic medical expenses (as defined in section 1861(ff)(1)) for a calendar year.

PAYMENT OF BENEFITS

Sec. 1833. (a) * * *

* * * * * * *

(3) in the case of services described in subparagraphs (D) and (E) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A) and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion) exceed 80 percent of such costs; [and]

(4) in the case of facility services described in section 1832(a)(2)(F), and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i)[.]*; and*

(5) in the case of catastrophic medical expenses described in section 1832(a)(3), 100 percent of such expenses.

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75; except that (1) such total amount shall not include expenses incurred for items and services described in section 1861(s)(10)(A), (2) such deductible shall not apply with respect to home health services, (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1), or to a provider having an agreement under section 1866, or (B) on the basis of a negotiated rate determined under subsection (h)(6), [and] (4) such deductible shall not apply with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion). The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence*, and (5) such deductible shall not apply with respect to the benefits described in section 1832(a)(3).*

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections **[**(a) and (b)**]** *(a), (b), and (f)* only whichever of the following amounts is the smaller:

(1) $312.50, or

(2) 62½ percent of such expenses.

* * * * * * *

(d) No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1813 *or section 1813A*) to have payment made with respect to such services under part A.

(e) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

(f) In applying subsection (a)(5) in the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876 or in the case of a renal dialysis facility—

(1) the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect, in the aggregate, the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such clause or such a contract or with respect to individuals furnished services through the facility if payments were to be made on an individual-by-individual basis, and

(2) the organization or facility shall provide assurances satisfactory to the Secretary that the organization or facility will not undertake to charge an individual during a year for any catastrophic medical expenses (as defined in section 1861(ff)(1)) incurred for that year.

(g) In the case of services described in the second sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections **[**(a) and (b)**]** *(a), (b) and (f).* In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b).

* * * * * * *

(m)(1) Not later than November 15 of each year (beginning with 1987), the Secretary shall promulgate the medicare catastrophic limit under this subsection for the succeeding year.

(2) The medicare catastrophic limit for 1988 is $1,700. The medicare catastrophic limit for any succeeding year shall be an amount equal to the medicare catastrophic limit for the preceding year increased by the applicable increase percentage determined under section 215(i) in the previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) * * *

* * * * * * *

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. *For purposes of paragraph (2)(C), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker) or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences of the individual from home are infrequent or of relatively short duration.*

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a)(1) [The Secretary shall, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to those enrollees age 65 and older will equal one-half of the total of the benefit and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin.] *(A) The Secretary shall, during September of 1987 and of each year thereafter, determine the monthly actuarial basic rate for enrollees age 65 and over which shall be applicable for the succeeding calendar year. The monthly actuarial basic rate determined under this paragraph for a calendar year shall be the amount the Secretary estimates to be necessary so that the aggregate amount for the calendar year with respect to those enrollees age 65 and over will equal one-half of the total of the benefits and administrative costs that the Secretary estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees (excluding catastrophic coverage benefits and related administrative costs). In calculating the monthly actuarial basic rate, the Secretary shall include an appropriate amount for a contingency margin.*

(B) For purposes of this paragraph, the term "catastrophic coverage benefits" has the meaning given to such term in subsection (g)(2)(C)(i).

* * * * * * *

(3) The Secretary shall, during September of 1983 and of each year thereafter, determine and promulgate the monthly premium applicable for individuals enrolled under this part for the succeeding calendar year. The monthly premium shall (except as otherwise provided in [subsection (e)] *subsections (e) and (g)*) be equal to the smaller of—

* * * * * * *

[(4) The Secretary shall also, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to disabled enrollees under age 65 which will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.]

(4)(A) The Secretary shall also, during September of 1987 and of each year thereafter, determine the monthly actuarial basic rate for disabled enrollees under age 65 which shall be applicable for the succeeding calendar year. The monthly actuarial basic rate determined under this paragraph for a calendar year shall be the amount the Secretary estimates to be necessary so that the aggregate amount for the calendar year with respect to disabled enrollees under age 65 will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees (excluding catastrophic coverage benefits and related administrative costs). In calculating the monthly actuarial basic rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

(B) For purposes of this paragraph, the term "catastrophic coverage benefits" has the meaning given to such term in subsection (g)(2)(C)(i).

* * * * * * *

(e)(1) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month after December 1983 and prior to January 1989 shall be an amount equal to 50 percent of the monthly actuarial *basic* rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.

* * * * * * *

(g)(1) Notwithstanding any other provision of this section, except as provided in paragraph (3), the monthly premium otherwise determined under this section for an individual for each month in calendar year 1988 after March, and for every month in any succeeding calendar year shall be increased by an amount equal to the applicable monthly catastrophic coverage premium amount for that year.

(2)(A)(i) The monthly catastrophic coverage premium amount for 1988 for individuals who are covered by the insurance programs under part A and this part shall be $4. The monthly catastrophic coverage premium amount for such individuals for any succeeding calendar year shall be the monthly catastrophic coverage premium amount determined under this subparagraph for the preceding calendar year, increased (or decreased) by the percentage increase (or decrease) in the per enrollee actuarial comprehensive catastrophic benefit amount for the year for which the determination is made over the per enrollee actuarial comprehensive catastrophic benefit amount for such preceding year. For purposes the preceding sentence, in determining the percentage increase (or decrease) in the per enrollee actuarial comprehensive catastrophic benefit amount for calendar year 1989 over the per enrollee actuarial comprehensive catastrophic benefit amount for calendar year 1988, the total of the catastrophic coverage benefits (and related administrative costs) payable with respect to enrollees under this part in calendar year 1988 shall be computed as if the medical catastrophic limit under section 1833(m) applied to out-of-pocket medical expenses incurred for the entire calendar year. For any calendar year beginning after

1992, the Secretary shall adjust the monthly catastrophic coverage premium amount by the percentage determined under section 1839A(b)(2)(B)(ii)(iv).

(ii) The monthly catastrophic coverage premium amount for any calendar year for individuals who are covered by the insurance program under this part but not by the insurance program under part A shall be an amount that bears the same ratio to the monthly catastrophic coverage premium amount determined under clause (i) for such year as the actuarial part B catastrophic benefit amount for such year bears to the actuarial comprehensive catastrophic benefit amount for such year.

(B) If any monthly premium amount determined under subparagraph (A) is not a multiple of 10 cents, such premium amount shall be rounded to the nearest multiple of 10 cents.

(C) For purposes of this paragraph—

(i) the term "catastrophic coverage benefits" means benefits payable under this title by reason of the enactment of the amendments made by sections 2(a), 3(a), 4, and 7(b) of the Medicare Catastrophic Loss Prevention Act of 1987,

(ii) the term "per enrollee actuarial comprehensive catastrophic benefit amount" means, with respect to a year, an amount equal to the actuarial comprehensive catastrophic benefit amount for the year divided by the total number of individuals that the Secretary estimates will be enrolled under this part for the year,

(iii) the term "actuarial comprehensive catastrophic benefit amount" means, with respect to a calendar year, the amount that the Secretary estimates will equal the total of the catastrophic coverage benefits (and related administrative costs) that will be payable from the Federal Supplementary Medical Insurance Trust Fund and from the Federal Hospital Insurance Trust Fund in such calendar year with respect to enrollees under this part, and

(iv) the term "actuarial part B catastrophic benefit amount" means, with respect to a calendar year, the amount the Secretary estimates will equal the total of the catastrophic coverage benefits (and related administrative costs) that will be payable from the Federal Supplementary Medical Insurance Trust Fund in such calendar year with respect to such enrollees (excluding any amounts transferred pursuant to section 1841(j)).

(3) For any calendar year after 1988, if an individual is entitled to monthly benefits under section 202 or 223 for November and December of the preceding year, and if the monthly premium of the individual under this section for December and for January is deducted from those benefits under section 1840(a)(1), the monthly premium otherwise determined under this section for an individual for that year shall not be increased, pursuant to paragraph (1), to the extent that such increase would reduce the amount of benefits payable to that individual for that January below the amount of benefits payable to that individual for that December (after the deduction of the premium under this section).

SUPPLEMENTAL PREMIUM FOR INDIVIDUALS COVERED BY PART B

SEC. 1839A. (a)(1) Any individual described in paragraph (2) shall pay the applicable supplemental premium in the manner provided in subsection (c).

(2) An individual is described in this paragraph if such individual—

(A) is covered by the insurance program established under this part for any portion of any taxable year occurring after December 31, 1987, and

(B) has Federal income tax liability for such taxable year in an amount not less than $150.

(b) For purposes of this section—

(1) The term "applicable supplemental premium" means an amount equal to the product of—

(A) the number of months in the taxable year during which the individual was covered by the insurance program established under this part, multiplied by

(B) the supplemental premium.

(2)(A) The term "supplemental premium" means an amount equal to the product of—

(i) the premium rate for the taxable year, multiplied by

(ii) the amount determined by dividing—

(I) the individual's Federal income tax liability for such taxable year, by

(II) $150.

If any amount determined under clause (ii) is not a whole number, such amount shall be rounded to the next lowest whole number.

(B)(i) The premium rate for any taxable year beginning before 1989 is $1.02. The premium rate for any taxable year beginning in a calendar year after 1988 is the premium rate determined under this clause for taxable years beginning in the preceding calendar year, increased or decreased by the premium rate adjustment under clause (ii) for taxable years beginning in the calendar year for which the determination is made.

(ii)(I) For purposes of clause (i), the premium rate adjustment for taxable years beginning in a calendar year after 1988 is the percentage increase or decrease in the per enrollee actuarial comprehensive catastrophic benefit amount (within the meaning of section 1839(g)(2)(C)(ii)) for such calendar year over such amount for the preceding calendar year.

(II) The Secretary shall adjust the premium rate for any calendar year beginning after 1992 (without regard to this subclause and subclause (IV)) to appropriately reflect any percentage increase or decrease in the estimated average Federal income tax liability of individuals described in subsection (a)(2) for such calendar year over such average for the preceding calendar year.

(III) In determining the percentage increase (or decrease) under subclause (I) for calendar year 1989, the total of the catastrophic coverage benefits (within the meaning of section 1839(g)(2)(C)(i)) (and related administrative costs) payable with respect to enrollees under this part in calendar year 1988 shall

be computed as if the medicare catastrophic limit under section 1833(m) applied to out-of-pocket medical expenses incurred for the entire calendar year.

(IV) If the Secretary determines for any calendar year beginning after 1992 that the estimated total catastrophic coverage benefits (within the meaning of section 1839(g)(2)(C)(i)) and related administrative costs for such calendar year will exceed the estimated total revenues collectable with respect to such calendar year from the premiums under this section and the monthly catastrophic coverage premiums (within the meaning of section 1839(g)(2)(A)), the Secretary shall increase the premium rate under this section and the monthly catastrophic coverage premium for such calendar year by the percentage necessary to increase the estimated total revenues for such calendar year by the amount of such excess.

(3)(A)(i) In the case of a taxable year beginning in a calendar year after 1987 and before 1993, the applicable supplemental premimum for any individual shall not exceed the amount which bears the same ratio to the amount determined under the table in clause (ii) as—

(I) the number of months determined under paragraph (1)(A), bears to

(II) 12.

(ii) For purposes of clause (i)—

If the taxable year begins in:	*The amount is:*
1988	*$800*
1989	*850*
1990	*900*
1991	*950*
1992	*1,000.*

(B) In the case of a taxable year beginning in a calendar year after 1992, the applicable supplemental premium for any individual shall not exceed an amount equal to 65 percent of the product of—

(i) the number of months determined under paragraph (1)(A), multiplied by

(ii) the excess of—

(I) the sum of 200 percent of the monthly actuarial basic rate for enrollees age 65 or over (as determined under section 1839), and the monthly per enrollee actuarial comprehensive catastrophic benefit amount for such calendar year, over

(II) the sum of the basic and catastrophic monthly premiums for such year (as determined under section 1839 without regard to subsections (f)(2) and (g)(3) thereof).

(4)(A) Except as provided in this paragraph, in the case of married individuals (within the meaning of section 7703 of the Internal Revenue Code of 1986)—

(i) who file a joint return under section 6013 of such Code, and

(ii) 1 or both of whom are described in subsection (a)(2) with respect to such taxable year,

the applicable supplemental premiums shall be determined by treating such individuals as 1 individual.

(B) If subparagraph (A) applies, the number of months taken into account under paragraph (1)(A) (other than for purposes of paragraph (3)) shall be determined by reference to the spouse who was covered by the insurance program established under this part for the longer period during the taxable year (or if covered for the same period, either spouse).

(C) If subparagraph (A) applies and both spouses are covered during the taxable year by the insurance program established under this part, the limitation under paragraph (3) shall be equal to the sum of the limitations computed separately under paragraph (3) for each of the spouses.

(c)(1) Except as provided in paragraph (2), for purposes of the Internal Revenue Code of 1986 (other than section 15 of such Code), any applicable supplemental premium required to be paid under subsection (a)(1) shall be treated as an addition to the tax imposed by chapter 1 of such Code for the taxable year to which such premium relates.

(2) Any applicable supplemental premium required to be paid under subsection (a)(1) shall not be treated as an addition to the tax imposed by chapter 1 of the Internal Revenue Code of 1986 for purposes of determining—

(A) the amount of any credit allowable under such chapter, or

(B) the amount of the minimum tax imposed by section 55 of such Code.

(d)(1) For purposes of this section, the term "Federal income tax liability" means—

(A) the tax imposed by chapter 1 of the Internal Revenue Code of 1986 (without regard to this section), reduced by

(B) the amount of the credits allowed under part IV of subchapter A of such chapter (other than sections 31, 33, and 34).

(2) For purposes of section 213(d)(1)(C) of the Internal Revenue Code of 1986, the applicable supplemental premium under subsection (a)(1) shall be treated as a premium paid under this part in the taxable year following the taxable year to which such premium relates.

(e) The Secretary of the Treasury shall, from time to time, transfer from the general fund of the Treasury to the Federal Supplementary Medical Insurance Trust Fund amounts equal to the sum of—

(1) the aggregate monthly supplemental premiums paid pursuant to this section, plus

(2) the amount which the Secretary estimates Federal outlays are reduced under title XIX of this Act by reason of the amendments made by sections 2(a), 3(a), 4, and 7(b) of the Medicare Catastrophic Loss Prevention Act of 1987 (after taking into account the provisions of section 14 of such Act).

Such transfer shall be appropriately adjusted to the extent that prior transfers were in excess of or less than the amounts required to be transferred.

PAYMENT OF PREMIUMS

SEC. 1840. (a)(1) In the case of an individual who is entitled to monthly benefits under section 202 or 223, his monthly premiums under this part shall [except as provided in subsections (b)(1) and (c))] *(except as provided in section 1839A(a)(2) and subsections (b)(1) and (c) of this section)* be collected by deducting the amount thereof from the amount of such monthly benefits. Such deduction shall be made in such manner and at such times as the Secretary shall by regulation prescribe.

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FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

SEC. 1841. (a) * * *

* * * * * * *

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Administrator of the Health Care Financing Administration shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

* * * * * * *

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall also include *an evaluation of the extent to which the premiums collected under sections 1839(g) and section 1839A are sufficient to pay for catastrophic coverage benefits (as defined in section 1839(g)(2)(C)(i)) and related administrative expenses payable from the Trust Fund and* an actuarial opinion by the Chief Actuarial Officer of the Health Care Financing Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall be printed as a House document of the session of the Congress to which the report is made.

* * * * * * *

(j) There shall be transferred from time to time from the Trust Fund to the Federal Hospital Insurance Trust Fund amounts from

the premiums under this part that are attributable to the changes (under sections 2(a), 3(a), and 7(b) of the Medicare Catastrophic Loss Prevention Act of 1987) in services performed and related administrative costs incurred in such calendar year with respect to individuals who are covered under the insurance program established by part A.

PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) The term "spell of illness" with respect to any individual means a period of consecutive days—

* * * * * * *

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) * * *

* * * * * * *

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. *For purposes of paragraphs (1) and (4), nursing care and home health aide services may be provided under such paragraphs seven days a week (with one or more visits per day) for a period of up to 21 days with a physician's certification of the need for such care and services on such a basis. In the case of an individual who is covered under the insurance program established under part B, and who is furnished nursing care and home health aide services within 30 days after being discharged from a hospital or a skilled nursing facility, the preceding sentence shall be applied by substituting "45 days" for "21 days".*

* * * * * * *

Reasonable Cost

(v)(1)(A) * * *

* * * * * * *

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute [post-hospital extended care services] *extended care services or post-hospital extended care services* if provided by a skilled nursing facility and a quality control and peer review organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary may designate) determines that inpatient hospital services for the individual are not medically necessary but [post-hospital extended care services] *extended care services or post-hospital extended care services* for the individual are medically necessary [and such extended care services] *and such services* are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

(I) such [post-hospital extended care services] *extended care services or post-hospital extended care services* for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for [post-hospital extended care services] *extended care services or post-hospital extended care services* under this title,

except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) on the basis of the amount otherwise payable under part A with respect to inpatient hospital services.

* * * * * * *

(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services), *extended care services,* or post-hospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed the amount that would be taken into account with respect to such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

(B) Where a provider of services which has an agreement in effect under this title furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the items or services with respect to which such payment may be made.

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services), *extended care services,* or post-hospital extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such

bed and board under part A shall be the amount otherwise payable under this title for such bed and board furnished in semi-private accommodations minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

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Post-Hospital Extended Care in Christian Science Skilled Nursing Facilities

(y)(1) * * *

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[(2) Notwithstanding any other provision of this title, payment under part A may not be made for services furnished an individual in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a spell of illness to have such services treated as post-hospital extended care services for purposes of such part; and payment under part A may not be made for post-hospital extended care services—

[(A) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) applies after—

[(i) such services have been furnished to him in such a facility for 30 days during such spell, or

[(ii) such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph does not apply; or

[(B) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph applies.

[(3) The amount payable under part A for post-hospital extended care services furnished an individual during any spell of illness in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day before the 31st day on which he is furnished such services in such a facility during such spell (and the reduction under this paragraph shall be in lieu of any reduction under section 1813 (a)(3)).]

(2)(A) Notwithstanding any other provision of this title, payment may not be made under part A for services furnished to an individual who is covered by the insurance programs under such part and part B in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a calendar year to have such services treated as extended care services for purposes of such part; and payment under part A may not be made for extended care services—

(i) furnished to an individual during such year in a skilled nursing facility to which paragraph (1) applies after—

(I) such services have been furnished to him in such a facility for 30 days during such year, or

(II) such services have been furnished to him during such year in a skilled nursing facility to which such paragraph does not apply; or

(ii) furnished to an individual during such year in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such year in a skilled nursing facility to which such paragraph applies.

(B) In the case of an individual who is covered by the insurance program under part A but not by the insurance program under part B, the provisions of subparagraph (A) shall be applied by substituting "spell of illness" for "calendar year", by substituting "spell" for "year" each place it appears, and by substituting "post-hospital extended care services" for "extended care services" each place it appears.

(3)(A) The amount payable under part A for extended care services furnished during any calendar year in a skilled nursing facility to which paragraph (1) applies to an individual who is covered by the insurance programs established under such part and part B shall be reduced by a coinsurance amount equal to the coinsurance amount established under section 1813(a)(3)(C) for each day before the 10th day.

(B)(i) The amount payable under part A for post-hospital extended care services furnished during any calendar year to an individual who is covered by the insurance program established under such part but not by the insurance program established under part B in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day before the 31st day on which the individual is furnished such services in a facility during such spell (and the reduction under this paragraph shall be in lieu of any reduction under section 1813A(a)(3).

(ii) For purposes of this subparagraph—

(I) the "inpatient hospital deductible" for a year is the inpatient hospital deductible promulgated under section 1813 for that year, and

(II) the inpatient hospital deductible for a year shall apply to the coinsurance amounts under clause (i) for post-hospital extended care services furnished in that year.

* * * * * * *

Hospice Care; Hospice Program

(dd)(1) * * *

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(2) The term "hospice program" means a public agency or private organization (or a subdivision thereof) which—

(A)(i) * * *

* * * * * * *

(iii) provides assurances satisfactory to the Secretary that the aggregate number of days of inpatient care described in paragraph (1)(G) provided in any 12-month period to individuals who have an election in effect under section **[**1812(d)**]**

1812(c) with respect to that agency or organization does not exceed 20 percent of the aggregate number of days during that period on which such elections for such individuals are in effect;

* * * * * * *

(ff)(1) The term "catastrophic medical expenses" means, with respect to an individual for a calendar year (beginning with 1988), any beneficiary cost sharing amounts (as defined in paragraph (2)) incurred by an individual in the year after the individual has incurred out-of-pocket medical expenses (as defined in paragraph (3)) in the year in an amount equal to the medicare catastrophic limit established under section 1833(m) for the year.

(2) The term "beneficiary cost sharing amounts" means the amounts of expenses that an individual who is covered by the insurance program established under part B incurs that are attributable to—

(A) the deductions and coinsurance amounts established under section 1813(a) and under subsection (y)(3),

(B) the deductions established under section 1833(b), or

(C) the difference between the payment amount provided under part B and the payment amount that would be provided if "100 percent" and "0 percent" were substituted for "80 percent" and "20 percent", respectively, each place either appears in section 1833(a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

(3) The term "out-of-pocket medical expenses" means the amounts expended by an individual who is covered under the insurance program established under part B that are—

(A) beneficiary cost sharing amounts,

(B) amounts expended by an individual described in subsection (s)(2)(J) for immunosuppressive drugs furnished after the 1-year period specified in such subsection (in amounts not to exceed the reasonable charges for such drugs), and

(C) amounts expended for qualified examinations for the early detection of cancer (in amounts not to exceed the reasonable charges for such examinations).

(4) An examination that is performed with respect to an individual covered by the insurance program under part B shall be treated as a "qualified examination for the early detection of cancer" if the examination is—

(A) a routine mammogram for the purpose of the diagnosis of breast cancer that is performed with respect to an individual who—

(i) has attained age 55, and

(ii) has not had a mammogram on a routine basis during the preceding 36 months; or

(B) a routine colorectal examination for the purpose of the diagnosis of colorectal cancer that is performed with respect to an individual who—

(i) has attained age 65, and

(ii) has not had a colorectal examination on a routine basis during the preceding 12 months.

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

* * * * * * *

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section [1813 (a)(1), (a)(3), or (a)(4)] *paragraph (1), (3), or (4) of section 1813, paragraph (1) or (3) of section 1813A,* section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A), with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), and with respect to clinical diagnostic laboratory tests for which payment is made under part B or which are durable medical equipment furnished as home health services. *A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1833(a)(5) (relating to catastrophic medical expenses).*

* * * * * * *

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1813(a)(2) *or section 1813A(a)(2),* except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of subparagraph (C), whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1813(a)(2) *or section 1813A(a)(2).*

* * * * * * *

(b) An agreement with the Secretary under this section may be terminated—

(1) * * *

* * * * * * *

Any termination shall be applicable—

(3) in the case of inpatient hospital services (including inpatient psychiatric hosptial services), *extended care services,* or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination,

* * * * * * *

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 186(k) of long-stay cases in a hospital or skilled nursing facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for *extended care services or* post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of a skilled nursing facility) to the facility and the hospital or hospitals with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)(1)) may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (c). Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards and requirements set forth in subsection (c). **[**Such certification**]** *Subject to subsection (k)(3), such certification* shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) such standards and requirements, he shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may prescribe) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received his certification.

(b)(1) Any medicare supplemental policy issued in any State which the Supplemental Health Insurance Panel (established under paragraph (2)) determines has established under State law a regulatory program that—

(A) provides for the application of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A));

[(B) includes a requirement equal to or more stringent than the requirement described in subsection (c)(2); and]

(B) includes requirements equal to or more stringent than the requirements described in paragraphs (2) and (3) of subsection (c);

(C) provides that—

(i) information with respect to the actual ratio of benefits provided to premiums collected under such policies will be reported to the State on forms conforming to those developed by the National Association of Insurance Commissioners for such purpose, or

(ii) such ratios will be monitored under the program in an alternative manner approved by the Secretary; and

[(C)]*(D)* provides for application of the standards and requirements described in subparagraphs [(A) and (B)] *(A), (B), and (C)* to all medicare supplemental policies (as defined in subsection (g)(1)) issued in such State,

shall be deemed [(for so long as] *(subject to subsection (k)(3), for so long as* the Panel finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in subsection (c).

* * * * * * *

(c) The Secretary shall certify under this section any medicare supplemental policy, or continue certification of such a policy, only if he finds that such policy—

(1) meets or exceeds (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another) the NAIC Model Standards; [and]

(2) can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of

the aggregate amount of premiums collected in the case of group policies and at least 60 percent of the aggregate amount of premiums collected in the case of individual policies[.], *and*

(3) may, during a period of not less than 30 days after the policy is issued, be returned for a full refund of any premiums paid (without regard to the manner in which the purchase of the policy was solicited).

* * * * * * *

(e)*(1)* The Secretary shall provide to all individuals entitled to benefits under this title (and, to the extent feasible, to individuals about to become so entitled) such information as will permit such individuals to evaluate the value of medicare supplemental policies to them and the relationship of any such policies to benefits provided under this title.

(2) The Secretary shall—

(A) inform all individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) of—

(i) the actions and practices that are subject to sanctions under subsection (d), and

(ii) the manner in which they may report any such action or practice to an appropriate official of the Department of Health and Human Services, and

(B) establish a toll-free telephone number for individuals to report suspected violations of the provisions of such subsection.

(3) The Secretary shall provide individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) with a listing of the addresses and telephone numbers of State and Federal agencies and offices that provide information and assistance to individuals with respect to the selection of medicare supplemental policies.

* * * * * * *

(k)(1)(A) If, within the period specified in subparagraph (B), the National Association of Insurance Commissioners (in this subsection referred to as the "Association") amends the NAIC Model Regulation adopted on June 6, 1979 (as it relates to medicare supplemental policies), to reflect the changes in law made by the Medicare Catastrophic Loss Prevention Act of 1987, subsection (g)(2)(A) shall be applied, effective on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the Model Regulation as amended by the Association in accordance with this paragraph (in this subsection referred to as the "amended NAIC Model Regulation").

(B) The period specified in this subparagraph is the period beginning on the date of the enactment of the Medicare Catastrophic Loss Prevention Act of 1987 and ending on the ninetieth day after such date.

(C) The date specified in this subparagraph is the date that is 365 days after the date (within the period specified in subparagraph (B)) on which the National Association of Insurance Commissioners announces the adoption of the amendments referred to in subparagraph (A).

(2)(A) If the Association does not amend the NAIC Model Regulation referred to in subsection (g)(2)(A) during the period specified in paragraph (1)(B), the Secretary shall issue Federal model standards (in this subsection referred to as "Federal model standards") for medicare supplemental policies not later than 90 days after the last day of such period. Federal model standards issued by the Secretary pursuant to this subparagraph shall reflect the changes in law made by the Medicare Catastrophic Loss Prevention Act of 1987.

(B) Effective on and after the date that is 365 days after the date on which the Secretary issues Federal model standards pursuant to subparagraph (A), this section shall be applied as if any reference to NAIC Model Standards were a reference to the Federal model standards.

(3) Notwithstanding any other provision of this section, on and after the date specified in paragraph (1)(C) or the date specified in paragraph (2)(B) (as the case may be)—

(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

(B) no certification made pursuant to subsection (a) shall remain in effect, and

(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulation or the Federal model standards (as the case may be).

HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

SEC. 1883. (a)(1) * * *

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(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as **[**post-hospital extended care services**]** *extended care services or post-hospital extended care services* if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received **[**post-hospital extended care services**]** *extended care services or post-hospital extended care services* in like manner and to the same extent as if the services furnished to him had been **[**post-hospital extended care services**]** *extended care services or post-hospital extended care services* furnished by a skilled nursing facility under an agreement under section 1866.

* * * * * * *

(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital which would otherwise constitute [post-hospital extended care services] *extended care services or post-hospital extended care services* if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

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PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a)(1)(A)(i) * * *

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(b)(1) Nothwithstanding section 1814(b) but subject to the provisions of [section 1813] *sections 1813 and 1813A*, if the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B)) for a cost reporting period subject to this paragraph—

(A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus—

(i) 50 percent of the amount by which the target amount exceeds the amount of the operating costs, or

(ii) 5 percent of the target amount,

whichever is less; or

(B) are greater than the target amount, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1982, and before October 1, 1984, 25 percent of the amount by which the amount of the operating costs exceeds the target amount;

except that in no case may the amount payable under this title (other than on the basis of a DRG prospective payment rate determined under subsection (d)) with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a).

* * * * * * *

(d)(1)(A) Notwithstanding section 1814(b) but subject to the provisions of [section 1813] *sections 1813 and 1813A*, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

(i) beginning on or after October 1, 1983, and before October 1, 1984, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, 1987, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after October 1, 1987, is equal to the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges.

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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PAYMENT TO STATES

SEC. 1903. (a) * * *

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(g)(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876 or which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or intermediate care facility services for 60 days, skilled nursing facility services for 30 days, or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services, skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to paragraphs (26) and (31) of section 1902(a) whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812 *or section 1812A*.

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PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

SEC. 1915. (a) * * *

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(c)(1) * * *

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(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness) [and section 1902(a)(10)(B) (relating to comparability)], *section 1902(a)(10)(B) (relating to comparability), and section 1902(a)(10)(C)(i)(III) (relating to single standard for income and resource eligibility)*. A waiver under this subsection shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.

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INTERNAL REVENUE CODE OF 1986

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SEC. 6050F. RETURNS RELATING TO SOCIAL SECURITY BENEFITS.

(a) REQUIREMENT OF REPORTING.—The appropriate Federal official shall make a return, according to the forms and regulations prescribed by the Secretary, setting forth—

(1) the—

(A) aggregate amount of social security benefits paid with respect to any individual during any calendar year,

(B) aggregate amount of social security benefits repaid by such individual during such calendar year, [and]

(C) aggregate reductions under section 224 of the Social Security Act (or under section 3(a)(1) of the Railroad Retirement Act of 1974) in benefits which would otherwise have been paid to such individual during the calendar year on account of amounts received under a workmen's compensation act, and

(D) the number of months any individual is covered by the insurance program established under part B of title XVIII of the Social Security Act for such calendar year, and

* * * * * * *

(b) STATEMENTS TO BE FURNISHED TO PERSONS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

(1) the name of the agency making the payments *or determining the months of coverage*, and

(2) the aggregate amount of payments, of repayments, and of reductions, *and the number of months of coverage,* with respect to the individual required to be shown on such return.

The written statement required under the preceding sentence shall be furnished to the individual on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

(c) DEFINITIONS.—For purposes of this section—

(1) Appropriate federal official.—The term "appropriate Federal official" means—

(A) the Secretary of Health and Human Services in the case of social security benefits described in section 86(d)(1)(A) *and months of coverage described in subsection (a)(1)(D),* and

(B) the Railroad Retirement Board in the case of social security benefits described in section 86(d)(1)(B).

(2) Social security benefit.—The term "social security benefit" has the meaning given to such term by section 86(d)(1).

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OMNIBUS BUDGET RECONCILIATION ACT OF 1986

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Subtitle E—Medicaid and Maternal and Child Health

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PART 2—PROVISION OF SERVICES UNDER WAIVER AUTHORITY

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SEC. 9414. NEW JERSEY RESPITE CARE PILOT PROJECT.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall enter into an agreement with the State of New Jersey (in this section referred to as the "State") for the purpose of conducting a pilot project (in this section referred to as the "project") under title XIX of the Social Security Act for providing respite care services for [elderly and disabled individuals] *eligible individuals* in order to determine the extent to which—

* * * * * * *

(b) CONDITIONS.—The agreement with the Secretary under this section shall—

(1) provide that the project shall be administered by a State health services agency designated for such purpose by the Governor (which may be the State agency administering or responsible for the administration of the State plan for medical assistance under title XIX of the Social Security Act),

(2) provide that the State may submit a detailed proposal describing the project (in lieu of a formal request for the waiver of applicable provisions of title XIX of the Social Security Act) and that submission of such a description by the State will be treated as such a request for purposes of subsection (g),

[(2)]*(3)* provide that [if the project imposes any cost sharing requirements on participants who are eligible for benefits under title XIX of the Social Security Act, such requirements shall be imposed only in accordance with the provisions of section 1916 of such Act] *the State shall utilize a post-eligibility cost-sharing formula based on the available income of participants with income in excess of the nonfarm income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981),*

[(3)]*(4)* provide for a system of review to assure that respite care services are provided only to individuals reasonably determined to be in need of such services, and

[(4)]*(5)* meet such other requirements as the Secretary may establish for the proper and efficient implementation of the project.

[(c) DEFINITION.—For purposes of this section, the term "respite care service" shall include—

[(1) short-term and intermittent—

[(A) companion or sitter services (paid as well as volunteer),

[(B) homemaker and personal-care services,

[(C) adult day care, and

[(D) inpatient care in a hospital, a skilled nursing facility, or an intermediate care facility (not to exceed a total of 14 days for any indivdual); and

[(2) peer support and training for family caregivers (using informal support groups and organized counseling).]

(c) DEFINITIONS.—For purposes of this section—

(1) the term "eligible individual" means an individual—

(A) who is elderly or disabled,

(B)(i) whose income (not including the income of the spouse or family of the individual) does not exceed 300 percent of the amount in effect under section 1611(a)(1)(A) of the Social Security Act (as increased pursuant to section 1617 of such Act), or

(ii) in the case of an individual and spouse who are both dependent on a caregiver, whose combined incomes do not exceed such amount,

(C) at the option of the State, who meets a resource standard established by the State,

(D) who is at risk of institutionalization unless the individual's caregiver is provided with respite care, and

(E) who has been determined to meet the requirements of subparagraphs (A) through (D) in accordance with an application process designed by the State; and

(2) the term "respite care services" shall include—

(A) short-term and intermittent—

(i) companion or sitter services (paid as well as volunteer),

(ii) homemaker and personal careservices,

(iii) adult day care, and

(iv) inpatient care in a hospital, a skilled nursing facility, or an intermediate care facility (not to exceed a total of 14 days for any individual), and

(B) peer support and training for family caregivers (using informal support groups and organized counseling).

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(g) PROVISIONS SUBJECT TO WAIVER.—At the request of the State, the Secretary shall waive the following provisions of title XIX of the Social Security Act as they relate to the pilot project: section 1902(a)(1), section 1902(a)(10)(B), *section 1902(a)(10)(C)(i)(III),* section 1902(a)(13), and section 1902(a)(30). The Secretary may not waive any other provision of such title with respect to the pilot project.

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